

The social and economic impact of the Rotherham Social Prescribing Pilot: Main evaluation report

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**The social and economic
impact of the Rotherham
Social Prescribing Pilot:
*Main Evaluation Report***

September 2014



Rotherham Clinical Commissioning Group



The social and economic impact of the Rotherham Social Prescribing Pilot

Main Evaluation Report

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September 2014

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Executive Summary

This report is the final output from the independent evaluation of the innovative Rotherham Social Prescribing Pilot undertaken by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University. It provides a detailed assessment of the social and economic impact of the pilot from the perspective of key stakeholders.

What is social prescribing?

Social prescribing provides a way of linking patients' in primary care and their carers with non-medical sources of support within the community. It is tailor-made for voluntary and community sector (VCS)-led interventions and can result in:

- better social and clinical outcomes for people with long-term conditions (LTCs) and their carers
- more cost-efficient and effective use of NHS and social care resources
- a wider, more diverse and responsive local provider base.

Social Prescribing in Rotherham

The Rotherham Social Prescribing Pilot was delivered by Voluntary Action Rotherham (VAR) on behalf of NHS Rotherham CCG. It was funded for two years from April 2012 to March 2014 as part of a wider GP-led Integrated Case Management Pilot and aimed to increase the capacity of GP practices to meet the non-clinical needs of their patients with long-term conditions (LTCs). The pilot received around £1m as part of a programme to provide 'additional investment in the community' and began receiving referrals from September 2012 onwards. Over the course of the Pilot:

- 24 voluntary and community organisations (VCOs) received grants with a total value of just over £600,000 to deliver a menu of 31 separate social prescribing services
- 1,607 patients were referred to the service, of whom 1,118 were referred on to funded VCS services. In parallel, more than 200 referrals were made to non-funded VCS provision and more than 300 referrals were made to statutory services
- the five most common types of funded services referred to were information and advice, community activity, physical activities, befriending and enabling.

The Pilot was one of the largest of its kind, covering the whole of the borough. It has since been re-commissioned for a further year and forms part of Rotherham's multi-agency proposal to the Better Care Fund. Furthermore, in March 2014 the Pilot received the '*Excellence in Individual Participation Commissioner*' award at NHS England's *Excellence in Participation Awards 2014*. In addition, it has been influential in the development of NHS policy at a national level, including as part of the NHS' '*Improving general practice - a call to action*' initiative, which aims to support action with the potential to transform services in local communities and support general practice to improve outcomes and tackle inequalities.

Impact on the demand for hospital care

Using patient-level Hospital Episode Statistics (HES) the evaluation mapped over time Social Prescribing patients' use of hospital resources, including unplanned care, comparing the number of inpatient admissions, Accident and Emergency attendances and outpatient appointments before and after referral.

The analysis identified a clear overall trend that points to reductions in patients' use of hospital resources after they had been referred to Social Prescribing:¹

- Inpatient admissions reduced by as much as 21 per cent
- Accident and Emergency attendances reduced by as much as 20 per cent
- Outpatient appointments reduced by as much as 21 per cent
- Greater reductions in inpatient admissions and Accident and Emergency attendances were identified for patients who were referred on to funded VCS services.

Social impact

Patients who were referred to the Social Prescribing Pilot experienced improvements in their well-being and made progress towards better self-management of their condition. Analysis of well-being outcome data showed that, after 3-4 months, 83 per cent of these patients had experienced positive change in at least one outcome area. Importantly, when the results were broken down by category they showed that progress was made against each outcome measure and that a majority of low-scoring patients made progress.

These findings were reinforced by case study interviews with a number of Social Prescribing patients who experienced a range of well-being outcomes, including improved mental and physical health, feeling less lonely and socially isolated, becoming more independent, and accessing a wider range of welfare benefit entitlements.

Economic and social benefits

A number of positive economic benefits to commissioners linked to the Social Prescribing Pilot have been estimated:

- estimated total NHS cost reductions by the end of the pilot of £552,000: a return on investment of 50 pence for each pound (£1) invested
- potential NHS cost reductions of £415,000 in the first year post-referral when the service is running at full capacity
- if these benefits identified are fully sustained over a longer period
 - the costs of delivering the service for a year would be recouped after between 18 and 24 months
 - the five year cost reductions for commissioners for each full year of service delivery could be as high as £1.9 million: a return on investment of £3.38 for each pound (£1) invested
 - even if the benefits are sustained but drop-off at a rate of 33 per cent each year they could lead to total cost reductions of £807,000: a return on investment of £1.41 for each pound (£1) invested.

¹ At this stage these figures are estimates based on only partial data on a sub-set of Social Prescribing beneficiaries. It will be possible to refine these estimates in future years once a longer time period has elapsed.

The value of a range of social benefits associated with Social Prescribing were also estimated using financial proxies and techniques associated with social return on investment (SROI) analysis:

- the estimated value of patients' well-being benefits was between £819,000 and £920,000 by the end of the pilot
- the potential value of well-being benefits is between £660,000 and £742,000 in the first year post-referral when the service is running at full capacity
- the estimated annual value of volunteering to the pilot was between £81,000 and £148,000: an additional £0.16 - £0.26 (16 - 26 pence) for each pound (£1) invested in the pilot by the CCG
- the estimated value of additional welfare benefits claimed was £350,000 over the course of the pilot
- the estimated value of additional funding accessed by funded VCS services providers was at least £200,000 over the course of the course of the pilot.

Conclusion

The findings from the evaluation of the Rotherham Social Prescribing Pilot demonstrate that economic and social benefits, or outcomes, have been created for three main stakeholder groups:

- **patients with LTCs and their carers** have experienced improved mental health, become more independent, less isolated, more physically active, and begun engaging with and participating in their local community. They have also been able to access a range of welfare benefits that they were previously unaware of. Social Prescribing services have provided these patients and carers with an important first step to engaging with community based services and wider statutory provision that they would not otherwise have been aware of.
- **the local public sector, in particular health bodies**, have benefitted because Social Prescribing patients' use of hospital resources - the number of inpatient stays, Accident and Emergency attendances and outpatients appointments - reduced by up to fifth in the 12 months following their referral to Social Prescribing. This translates into potential positive financial returns to commissioners in a relatively short period following the initial referral².

In addition, the local public sector has experienced broader outcomes. For example, patients accessing the service are generally more satisfied with the support they received and feel better supported to manage their condition. Furthermore, there is emerging evidence that non-health services, in particular social and residential care, benefit from similar reductions in resource utilisation and service delivery costs.³

- **the local voluntary and community sector (VCS)** has benefitted from a catalytic investment in community level service provision, which has enabled small organisations without a track record in health service provision to access NHS funding for the first time. Some providers have been able to 'match' their Social Prescribing with income from other sources, to enhance their provision and improve the overall sustainability of their organisation.

Overall, the pilot has demonstrated the potential for community based provision to make a positive and cost-effective contribution to local strategic health and well-being priorities, and provides a strong foundation for these types of providers to continue making a positive contribution through commissioned services in the future.

² At this stage these findings carry an important caveat: there are too few patients analysed and too little time has elapsed to produce findings that are statistically significant. In 12 months' time it will be possible to produce more statistically robust evidence, as a larger number of patients will have been tracked over a longer period.

³ Detailed analysis of social care data would be needed to properly quantify the extent of these reductions

Introduction

This report is the final output from the independent evaluation of the innovative Rotherham Social Prescribing Pilot. The Pilot was delivered by Voluntary Action Rotherham (VAR) in partnership with more than 20 local voluntary and community organisations (VCOs). It was commissioned by NHS Rotherham and funded from April 2012 to March 2014 as part of a wider GP-led Integrated Case Management Pilot with the aim of increasing the capacity of GP practices to meet the non-clinical needs of their patients with long-term conditions (LTCs), including support for their carers. At its core, the Rotherham Social Prescribing Pilot funded the provision of a voluntary and community sector (VCS) liaison service which:

- enabled patients and their carers to **access support from local VCS organisations**, with a view to improving health and well-being, and their ability to self-manage conditions
- for the first time, contributed a **VCS perspective to the assessment of needs** and care planning for patients referred to multi-disciplinary Integrated Case Management Teams (ICMTs)
- built capacity within the VCS, enabling **the development of new community-based services** with the potential to improve health and well-being and promote self-help and independence.

The Pilot received around £1m of funding from NHS Rotherham as part of a programme to provide 'additional recurrent investment in the community' during the transition from the Primary Care Trust (PCT) to the Clinical Commissioning Group (CCG).

1.1. About the evaluation

The evaluation was undertaken by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University. It had a number of aims:

- assess the impact of the pilot for its key stakeholders
- assess whether the aims and outcomes of the project had been achieved
- provide analysis of costs-benefits and return on investment, including assessing the cost savings and efficiencies to the NHS
- assess the effectiveness of the service delivery model
- establish a business case for future funding.

An interim evaluation report,⁴ published in December 2013, identified emerging lessons from the evaluation and provided a series of recommendations for stakeholders and commissioners going forward.

1.2. About this report

This final evaluation report provides an assessment of the social and economic impact of the pilot between September 2012 and March 2014. It draws on a variety of data sources:

- analysis of client management and monitoring data collected by VAR
- analysis of hospital episodes data for a cohort of beneficiaries of the Pilot
- in-depth interviews with public sector stakeholders, project staff, and voluntary and community organisations (VCOs) delivering services
- case studies involving service beneficiaries
- an online survey of funded VCS providers.

The report is divided into the following chapters:

- Chapter 2 provides an introduction to social prescribing
- Chapter 3 provides an overview of the activities and outputs of the pilot
- Chapter 4 provides analysis of the impact of the pilot on the demand for hospital care
- Chapter 5 provides analysis of the social impact of the pilot
- Chapter 6 provides analysis of the economic and social cost-benefits of the pilot
- Chapter 7 is the conclusion and outlines the business case for continuing Social Prescribing in Rotherham
- Appendix 1 provides five detailed case studies of services provided through the Pilot
- Appendix 2 provides a summary of all services funded through the Pilot.

⁴ <http://www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/rotherham-social-prescribing-final.pdf>

What is social prescribing?

2

This chapter provides an introduction to social prescribing and discusses the context in which the Rotherham Pilot was developed. It begins by discussing the main policy developments of the past few years before giving an overview of the ideas that underpin social prescribing and the different models that have been developed. It concludes by outlining the innovative social prescribing model enacted in Rotherham, including the structures and processes that enabled it to function effectively.

2.1. Policy Context

The Pilot emerged at an important time for the NHS at a local level. The announcement that GPs will take over the commissioning role previously undertaken by Primary Care Trusts (PCTs) was made in the 2010 White Paper, 'Equity and Excellence: Liberating the NHS.' It was part of wider Government moves to create a clinically driven commissioning system that is more sensitive to the needs of patients. The 2010 White Paper became law under the Health and Social Care Act 2012 in March 2012.

PCTs have been replaced by Clinical Commissioning Groups (CCGs) which operate by commissioning healthcare services including:

- elective hospital care
- rehabilitation care
- urgent and emergency care
- most community health services
- mental health and learning disability services.

CCGs were developed to give GPs and other clinicians more influence over commissioning decisions for their patients. They are responsible for coordinating emergency and urgent care services within their boundaries, which tend to be coterminous with local authorities. They involve healthcare professionals working in partnership with patients, local communities and statutory agencies to meet the health needs of local people. All NHS GP practices must belong to a CCG.

In addition to these developments, the Marmot Review (2010) has been particularly influential in shaping health policy at all levels. The Review found that people in the poorest neighbourhoods die sooner and spend more of their lives with a disability. As a result, people who live in deprived communities, or who are marginalised in terms of access to health and well-being information, support and services in other ways, are more likely to:

- present late with long-term conditions (LTCs)
- require emergency or unscheduled care
- experience greater co-morbidity
- be less likely to attend routine GP appointments for reviews of their condition and attend specialist clinics and outpatient appointments.

These factors combine to make these patients more complex to manage clinically, and increase their risk of experiencing complications associated with poor management of their condition. They also result in higher than average use of emergency care, unscheduled care and complex clinical interventions and are, ultimately, a greater cost burden to the State.

2.2. An introduction to social prescribing

Solutions for improving the health and well-being of people from marginalised and disadvantaged groups that place greater emphasis on preventative interventions have become increasingly common in public policy. This is reflected in the public health White Paper, 'Healthy Lives, Healthy People', which states:

“...it is not better treatment, but prevention – both primary and secondary... which is likely to deliver greater overall increases in healthy life expectancy.”

One such solution, often referred to as social prescribing, focuses on secondary prevention by commissioning services that will prevent worsening health for people with existing LTCs, and reduce costly interventions in specialist care. Social prescribing links patients in primary care and their carers with non-medical sources of support within the community. It is tailor-made for VCS-led interventions and can result in:

- better social and clinical outcomes for people with LTCs and their carers
- more cost efficient and effective use of NHS and social care resources
- a wider, more diverse and responsive local provider base.

As such, social prescribing provides GPs with a non-medical option that can operate alongside existing treatments and enable a more holistic approach to improving health and well-being.

2.3. Models of social prescribing

Social prescribing interventions can vary enormously, but often include:

- condition management programmes that provide support in areas such as education; managing pain and fatigue; healthy eating; exercise; emotional support; support for self-care; understanding care pathways; and self-help groups
- health and well-being support through activities such as interactive craft groups; interactive music sessions for people with dementia; community gardening projects; men's peer support groups; healthy cooking clubs; walking groups; specialist yoga; chair-based exercise; and assistive technology support
- support to access or maintain employment, education or wider community participation; including one-to-one support; group work; social activities; training,

apprenticeships; support to access community facilities; and community transport

- emotional and practical support through intervention such as peer mentoring; stroke communication groups; welfare rights and benefits advice; signposting; befriending; dementia cafes; gym buddies; support with aids and adaptations; handyperson services; and language support for people with learning disabilities or from BME communities
- specific support for carers, including respite care; short breaks; therapeutic activities; emotional and practical support, including peer support groups; and advice, information and guidance
- volunteering opportunities, such as peer mentors, befrienders, and community car drivers.

Social prescribing delivery models typically involve dedicated workers whose role is to liaise with providers and enable referred patients and carers to access the service prescribed. This might include assistance with overcoming practical barriers, moral support or confidence-building activities. Social prescribing can therefore be appropriate in a variety of circumstances:

- when a medical intervention is unlikely to work and a social intervention could be more appropriate
- when the patient appears to need alternative ways to channel their energies
- when the patient or carer could benefit from more integration or involvement with their local community
- when empowerment or self-help might enable a patient or carer to resolve their own difficulties.

2.4. Evidence in support of social prescribing

There is growing evidence that social prescribing works: evidence from similar pilot projects undertaken in the UK suggests that real changes can be identified after 18-24 months. Outcomes include:

- improved health and quality of life
- increased patient satisfaction
- fewer primary care consultations
- reductions in the number of hospital admissions, visits to Accident and Emergency, and outpatient attendances
- a decrease in the use of wider hospital resources.

Measuring progress against these and other linked outcomes is a key test of the Rotherham Social Prescribing Pilot's success, in particular the ability of local VCS providers to meet the needs of patients with LTCs and their carers, and become a more integral part of mainstream health and social care provision in the borough in the future.

2.5. The Rotherham Social Prescribing model

The Rotherham Social Prescribing Pilot was commissioned by NHS Rotherham as part of a GP-led Integrated Case Management Pilot. It aimed to increase the capacity of GPs to meet the non-clinical needs of patients with complex long-term

conditions (LTCs) who are the most intensive users of primary care resources.⁵ Specific support for the carers of case-managed patients was also provided. The Pilot received funding of £1.1 million between April 2012 and March 2014 to provide a voluntary and community sector (VCS) liaison service for the whole borough which:

- enabled patients and their carers to access support from local VCS organisations
- contributed a VCS perspective to the assessment of needs and care planning for patients referred to multi-disciplinary Integrated Case Management Teams (ICMTs)
- enabled the development of new community-based services to fill gaps in provision, and funded additional capacity within existing VCS to meet the increase in demand created by Social Prescribing.

44 per cent of the funding covered the core cost of developing and running the Pilot, with the remaining 56 per cent providing a grant funding pot for a 'menu' of VCS activities. The key components of the service are described below. Diagrammatic representation of the model is provided in Figure 2.1 (overleaf).

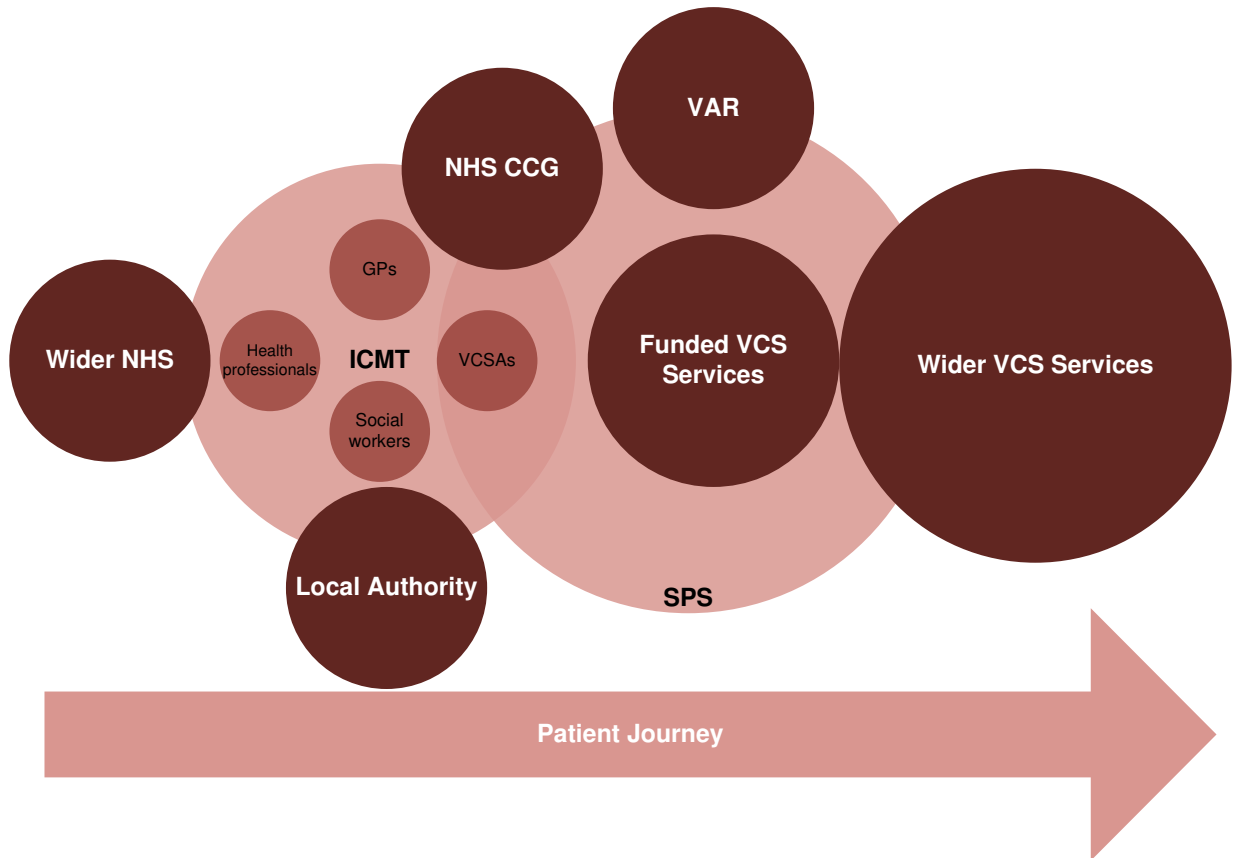
The Pilot became fully operational in September 2012. A core team consisting of a Project Manager and five Voluntary and Community Sector Advisors (VCSAs) was employed by VAR. The Project Manager's role was to oversee the day-to-day running of the Pilot, including management of the grant programme, and acting as a liaison between VCS providers and wider NHS structures. The VCSA role provided the link between the Pilot and the multidisciplinary ICMTs. They received referrals from GP practices of eligible patients and carers and made an assessment of their support needs before referring them on to appropriate VCS services. The assessment typically took place during a home visit where the VCSA would talk through the patient's needs and discuss the options available to them through social prescribing. VCSAs also formed part of the ICMT and attended meetings when Social Prescribing patients were being discussed.

The Pilot covered the whole of the borough of Rotherham. As such it was one of the largest of its kind, as the majority of social prescribing activity in the UK has had a much smaller geographic focus. It has since been re-commissioned for a further year and forms part of Rotherham's multi-agency proposal to the Better Care Fund.

The Pilot has also received national recognition: in March 2014 it received the '*Excellence in Individual Participation Commissioner*' award at *NHS England's Excellence in Participation Awards 2014*. In addition, it has been influential in the development of NHS policy at a national level, including as part of the NHS '*Improving general practice - a call to action*' initiative, which aims to support action with the potential to transform services in local communities and stimulate debate about how general practice can be supported to improve outcomes and tackle inequalities.

⁵ A risk stratification tool is used to identify the five per cent most intensive users of services: these patients and their carers are eligible for case management and can access social prescribing.

Figure 2.1: The Rotherham Social Prescribing Model



Social prescribing activities and outputs

This chapter provides an overview of the activities and outputs of the Rotherham Social Prescribing Pilot drawing on the comprehensive programme and client monitoring data collected by the VAR project team. It begins with an overview of the outputs and activities delivered between April 2012 and March 2014 before discussing in more detail the types of voluntary and community sector services provided and the range of referrals in to and out of the service.

3.1. The inception and development process

Although the Social Prescribing Pilot was commissioned in April 2012 the first referrals to the Pilot were not made until August 2012 and the majority of VCS services did not commence until January 2013 or later. Prior to this, time was spent getting the Pilot up and running. This included staff recruitment; developing relationships with GP practices and Case Management Teams, including raising awareness of the Pilot and the benefits of social prescribing for patients and carers; developing programme management systems, including a commissioning framework and grant monitoring systems; working to understand need and gaps in existing provision; and identifying and developing partnerships with the range of potential VCS providers across the borough.

Prior to April 2012 VAR, its VCS partners and NHS Rotherham had worked closely to establish the business case for Social Prescribing and develop a model of provision that could be embedded in the Case Management Pilot.

3.2. Commissioning from voluntary and community sector providers

The pilot commissioned services from local VCS organisations in two phases. The first phase was in autumn 2012 through which ten voluntary and community organisations (VCOs) were commissioned to deliver social prescribing services. Some of these services began receiving patients towards the end of 2012 (November/December) but the majority did not commence until January 2013 onwards. The second phase was in spring 2013 through which a further 13 VCOs were commissioned to deliver services. These services began receiving patients from June 2013 onwards. Overall, 24 VCOs received grants to deliver a menu of 31 separate social prescribing services. The value of these grants was £610,598: this included direct grants to the value of £506,266 and a 'floating fund' of £104,331, available for a range of non-grant funded services to be 'spot purchased'. Overall, funding for services commissioned from the VCS accounted for 56 per cent of the total project budget.

An overview of services funded through the pilot, including the number of referrals to each service throughout the Pilot is provided in Table 3.1. A more detailed summary is available in Appendix 2.

Table 3.1: Summary of funded social prescribing services in Rotherham

Service provider	Type of service or activity	No of referrals	
		2012/13	2013/14
Active Independence	Peer advocacy with volunteering opportunities	10	63
Active Regen	Group activity/mobility sessions; Senior peer mentoring - 'Active Friends' buddy scheme	-	89
Age UK Rotherham	Advice and Information Reablement service Befriending service	104	373
Alzheimers Society	Dementia Support Worker Service Dementia Volunteer Befriending service	30	117
British Red Cross	Volunteer-led befriending and enabling service	-	78
Crossroads Care	Respite service Complimentary therapies Carers peer support group	14	172
Elmet Archaeological Services Ltd	Drop-in reminiscence group	-	18
High Street Centre	Activity Co-ordinator	3	46
Kimberworth Park Community Partnership	Home visits and referral to community activities	12	152
Montgomery Hall	Activity Co-ordinator	11	34
Rotherham Community Transport	Volunteer driver scheme and improved booking and scheduling service	55	155
Rotherham Ethnic Social Care Organisation	Group activity programmes for BME carers	-	18
Rotherham Titans Community Foundation	Home visits from Rotherham Titans first team players Group activities at Clifton Lane Sports Ground	-	88
Rotherham United Community Sports Trust	Home Exercise visits New York Stadium activity sessions Community based activity sessions	36	167
Royal Voluntary Service	Volunteer-led good neighbours befriending and enabling scheme	-	43
Satori Counselling	One-to-one therapeutic counselling and additional group work sessions	-	20
Self Management UK	Caring with Confidence course	-	21
Sense	Sensory art & craft group sessions	-	69

South Yorkshire Centre for Inclusive Living	One-to-one Support Worker Facilitated 'afternoon tea' sessions	29	234
Sure Health	Community based Tai Chi classes	-	57
Tassibee	One-to-one peer advocacy and enabling service for BME women	5	13
Unity Centre	Group activity sessions for Asian men	2	16
Universal Embrace	Complimentary Therapy and social group sessions	31	136
You Ask We Respond	Advocacy Befriending and enabling Group Activities Sitting Service	4	51

3.3. Social prescribing referrals

The section provides an overview of social prescribing referral patterns.⁶ It covers both referrals-in to the Pilot (i.e. by GPs and ICMTs to VCSAs) and referrals-out (i.e. by VCSAs to funded VCS services and wider provision).

Referrals-in to social prescribing

Between September 2012 and March 2014 the Pilot actively engaged with 29 (out of 36) GP practices in Rotherham to receive referrals-in from ICMTs as part of the Case Management Pilot. Overall, 1,607 referrals-in were received compared to an initial target of 940. Within these referrals a number of patterns were evident.

Age

The majority of patients referred to the pilot were elderly:

- 87 per cent were aged 60 or over
- 75 per cent were aged 70 or over
- 47 per cent were aged 80 or over
- 10 per cent were aged 90 or over

Gender

Females (61 per cent) were more likely to be referred to the pilot than males (39 per cent).

Ethnicity

A large majority of referred patients were from a White ethnic background (91 per cent) with fewer than five per cent from other ethnic backgrounds.⁷

⁶ Note that although the headline figures presented are for the whole 2 years of the Pilot detailed analysis of referrals is based data collected by the Pilot up to the end of January 2014: 1,329 of the total 1,607 referrals-in to the service.

⁷ 6 per cent of SPS clients' ethnicity was not stated

GP practice

The volume of referrals-in to the Social Prescribing Pilot varied considerably by GP practice. Four practices referred more than 100 patients, five referred between 50 and 100 patients, 12 referred between 25 and 49 patients and ten referred less than 25 patients (including three that referred less than 10).

Table 3.2: Summary of GP referrals to the Rotherham Social Prescribing Pilot

	No of Patients Referred to SPS				
	100 plus	50-100	25-49	10-24	Less than 10
Dinnington Group Practice	■				
Morthen Road Surgery	■				
Swallownest Health Centre	■				
Clifton Lane Corner Surgery	■				
Parkgate Medical Centre		■			
Broom Lane Medical Centre		■			
Kiveton Primary Care Centre		■			
Market Surgery		■			
Blyth Road Medical Centre		■			
St Ann's Medical Centre			■		
Kilnhurst Surgery (Magna Group)			■		
Village Surgery Thurcroft			■		
York Road Surgery			■		
Shakespeare Road Surgery			■		
Crown Street Surgery			■		
Rawmarsh Health Centre			■		
Stag Medical Centre			■		
High Street Surgery			■		
Manorfield Surgery			■		
Wickersley Health Centre			■		
Greasbrough Medical Centre			■		
Maltby Service Centre				■	
Thorpe Hesley Surgery				■	
Greenside Surgery				■	
Queens Medical Centre				■	
Broom Valley Road Surgery				■	
Thrybergh Medical Centre				■	
Woodstock Bower Group Practice				■	

Brinsworth Medical Centre						
Treeton Medical Centre						
Surgery of Light						

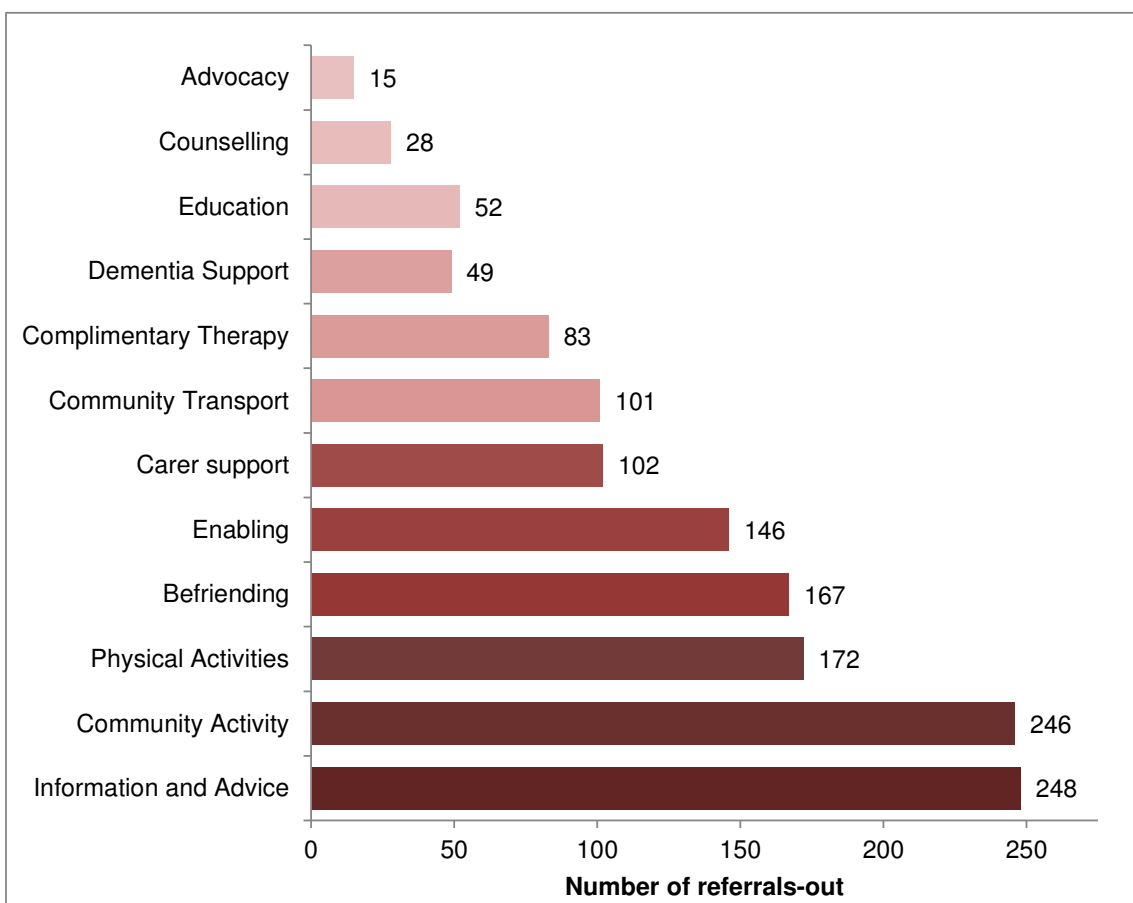
Referrals-out

Funded VCS services

Over the course of the Pilot there were 2,584 onward referrals of 1,118 patients (many had more than one onward referral) to funded VCS services. Figure 3.1 provides an overview of referrals-out to the VCS by service type.

Although some types of service received particularly high numbers of referrals - information and advice and community activity for example - what is particularly striking is the broad range of services that were accessed through Social Prescribing. In addition, the high demand for services such as befriending and community transport highlights the importance of services that aim to reduce dependence and social isolation. These types of intervention might be seen as a 'first step' for patients aiming to access a wider range of community provision more independently in future.

Figure 3.1: Overview of referrals out to funded VCS services by service type (Sept 2012-Jan 2013)



Multiple referrals to funded provision were also a notable feature of the Pilot. More than half of all (53 per cent) patients referred-out to grant funded provision through the Pilot were referred to more than one service. Of these, 26 per cent received two referrals-out, 15 per cent received three, 7 per cent received four, and 4 per cent received five or more.

Wider VCS provision

In addition to referrals to VCS services in direct receipt of funding through the Social Prescribing Pilot, 15 per cent of patients were referred to the wider pool of VCS provision available in the borough. This included other services available from existing Social Prescribing providers such as Age UK (for example gardening and cleaning services) as well as services available from other VCS organisations such as Headway and Stayput.

This highlights how the Pilot served as a gateway to a wider pool of VCS provision, and the added value this brings to commissioners and GPs, who would have otherwise been unable to link patients with these types of services.

Statutory provision

A further, unexpected function of the Pilot was to make referrals-out to statutory sector services; 22 per cent of patients were referred to additional statutory provision. The most common of these were RMBC OT Assessment and Intermediate Care and the Fire Brigade for fire safety checks, but referrals were also made to NHS services such as Breathing Space and community-level services such as falls prevention classes and community alarms. Although it cannot be said for certain that these referrals would not have occurred eventually through other means, in many cases it has ensured that the referral happened sooner rather than later.

4

Impact on the demand for hospital care

This chapter presents analysis exploring the impact of the Rotherham Social Prescribing Pilot on demand for hospital-based health interventions. It draws on patient-level Hospital Episode Statistics (HES) provided by the NHS to map over time the use of hospital resources by patients referred to the Social Prescribing Service since the Pilot's inception. Three types of hospital episode are considered: inpatient admissions; accident and emergency attendances; and outpatient appointments.

4.1. Methodology

Data sources and variables

The analysis presented in this chapter is based on pseudonymised patient-level hospital episode data for Social Prescribing patients provided by the NHS Data Management and Integration Centre (DMIC). Data linkage was made using the NHS numbers of Social Prescribing patients provided by Voluntary Action Rotherham. All inpatient stays, accident and emergency presentations, and outpatient appointments between April 2011 and December 2013 were included in the data. An overview of all variables included in the data set is provided in Table 4.1.

Table 4.1: Overview of HES variables provided by DMIC

General Variables	Admissions Variables	A and E Variables	Outpatient Variables
GP practice code	Destination at Discharge	Outcome	Outcome
Admission or attendance type	Primary diagnosis on admission	A&E diagnosis	Emergency assessment flag
Month of admission or attendance	Primary procedure on admission	Hospital Reference Group code	
Year of admission or attendance	Length of stay in days from admission to discharge		
Age group at admission or attendance	Hospital Reference Group code		
Patient gender			
Treatment			

Following exploratory analysis of all the data provided a series of outcome variables were created to provide the basis of the headline analysis presented in this report. These are outlined in Table 4.2.

Table 4.2: Overview of outcome variables

Inpatient admissions	A and E attendances	Outpatient appointments
No of inpatient admissions in the 6 months prior to referral	No of A and E attendances in the 6 months prior to referral	No of outpatient appointments in the 6 months prior to referral
No of inpatient admissions in the 12 months prior to referral	No of A and E attendances in the 12 months prior to referral	No of outpatient appointments in the 12 months prior to referral
No of inpatient admissions in the 6 months following referral	No of A and E attendances in the 6 months following referral	No of outpatient appointments in the 6 months following referral
No of inpatient admissions in the 12 months following referral	No of A and E attendances in the 12 months following referral	No of outpatient appointments in the 12 months following referral
Change in no of admissions in the 6 months following referral	Change in no of A and E attendances in the 6 months following referral	Change in no of outpatient appointments in the 6 months following referral
Change in no of admissions in the 12 months following referral	Change in no of A and E attendances in the 12 months following referral	Change in no of outpatient appointments in the 12 months following referral

Sampling

Analysis focussed on patients that were referred to the Social Prescribing Pilot during its first ten months of operation (September 2012-June 2013). For these patients sufficient time had elapsed post referral to begin observing changes in their utilisation of hospital services. Analysis was undertaken of two cohorts of patients referred to the Pilot:

- the **12 month cohort** included all patients for whom 12 months post-referral data was available i.e. all patients referred between September and December 2012 (n=108)
- the **six month cohort** included all patients for whom six months post-referral data was available i.e. all patients referred between September 2012 and June 2013 (n=451).

Analysis

Analysis was undertaken on both samples to measure changes in the use of hospital resources by Social Prescribing patients. As part of this analysis the changes experienced by a sub-group of patients who had been referred to funded VCS Social Prescribing services were also considered. For the 12 month cohort the number of each type of episode was compared for the 12 month periods before and after

referral to Social Prescribing. For the six month cohort the six month periods before and after referral were compared. Additional descriptive analysis was undertaken on both samples to explore the proportion of Social Prescribing patients who demonstrated an overall reduction in each type of service use.

An overview of the numbers in each sample is provided in Table 4.3.

Table 4.3: Overview of analysis groups and cohorts

	12 months	6 months
All patients referred to Social Prescribing	108	451
Social Prescribing patients referred to a grant funded provider	42	248

An overview of the analysis undertaken is presented in tables 4.4-4.7 and the main findings are discussed in the section that follows.

Table 4.4: Change in per-patient utilisation of hospital resources - 12 month cohort

	All patients referred to Social Prescribing			Patients referred to a grant funded VCS provider		
	12m before	12m after	Change	12m before	12m after	Change
No of inpatient admissions	1.46	1.17	-0.30	1.45	1.10	-0.36
No of A&E attendances	1.94	1.56	-0.39	2.19	1.67	-0.52
No of outpatient appointments	1.70	1.30	-0.36	1.90	1.36	-0.55

Table 4.5: Change in per-patient utilisation of hospital resources - six month cohort

	All patients referred to Social Prescribing			Patients referred to a grant funded VCS provider		
	6m before	6m after	Change	6m before	6m after	Change
No of inpatient admissions	0.59	0.51	-0.08	0.58	0.44	-0.13
No of A&E attendances	0.76	0.67	-0.09	0.75	0.63	-0.12
No of outpatient appointments	0.74	0.63	-0.11	0.72	0.69	-0.03

Table 4.6: Proportion of patients demonstrating a reduction in utilisation of hospital resources - 12 month cohort

	All patients referred to Social Prescribing		Patients referred to a grant funded VCS provider	
	n reduced	% reduced	n reduced	% reduced
Inpatient admissions	43	40	20	48
A&E attendances	41	38	18	43
Outpatient appointments	51	47	23	55

Table 4.7: Proportion of patients demonstrating a reduction in utilisation of hospital resources - six month cohort

	All patients referred to Social Prescribing		Patients referred to a grant funded VCS provider	
	n reduced	% reduced	n reduced	% reduced
Inpatient admissions	107	24	66	27
A&E attendances	113	25	66	27
Outpatient appointments	141	31	74	30

4.2. Summary of findings

Inpatients admissions

The 12 month cohort saw an overall reduction of 21 per cent in the number of inpatient admissions in the 12 month period following referral to Social Prescribing: patients referred to funded VCS services saw a greater reduction (0.36 per patient) than the full cohort (0.26 per patient) - a difference of 0.10 admissions per patient. Overall, 40 per cent of all referred patients saw a reduction in inpatient admissions but the proportion was greater for patients who had been referred to funded VCS services (48 per cent).

The pattern in the six month cohort was very similar. There was a small overall reduction (of 14 per cent) in the number of inpatient admissions in the six month period following referral to Social Prescribing with those patients who had been referred to funded VCS services seeing a greater reduction (0.13 per patient) than the full cohort (0.08) per patient) - a difference of 0.05 admissions per patient. Overall, 27 per cent of patients referred to a funded VCS service saw a reduction in inpatient admissions compared to 24 per cent of the full cohort.

Accident and Emergency attendances

Similar to inpatient admissions, the 12 month cohort saw an overall reduction in the number of Accident and Emergency attendances of 20 per cent in the 12 month period following referral to Social Prescribing: patients referred to a funded VCS service saw a greater reduction (0.52 per patient) than the full cohort (0.39 per patient) - a difference of 0.13 attendances per patient. Overall, 38 per cent of all

referred patients saw a reduction in Accident and Emergency attendances but the proportion was greater for patients who had been referred to funded VCS services (43 per cent).

Again, the pattern in the 12 month cohort was replicated in the six month cohort. There was a small overall reduction (of 12 per cent) in the number of Accident and Emergency attendances in the six month period following referral to Social Prescribing with those patients who had been referred to a funded VCS service seeing a greater reduction (0.12 per patient) than the full cohort (0.09) per patient) - a difference of 0.03 attendances per patient. Overall, 27 per cent of patients referred to a funded VCS service saw a reduction in Accident and Emergency attendances compared to 25 per cent of the full cohort.

Outpatient appointments

For the 12 month cohort the pattern identified for inpatient admissions and Accident and Emergency attendances was replicated in outpatient appointments. There was an overall reduction in the number of appointments of 21 per cent in the 12 month period following referral to Social Prescribing: patients referred to a funded VCS service saw a greater reduction (0.55 per patient) than the full cohort (0.36 per patient) - a difference of 0.19 appointments per patient. Overall, 47 per cent of patients saw a reduction in outpatient appointments but the proportion was greater for patients who had been referred to funded VCS services (55 per cent).

For the six month cohort the pattern was different to that shown in the rest of the analysis. There was a small overall reduction in the number of outpatient appointments (of 15 per cent) in the six month period following referral to Social Prescribing but the reduction was greater for the full cohort (0.11 per patient) than for patients who had been referred to a funded VCS service (0.03 per patient) - a difference of 0.8 appointments per patient. Overall, 31 per cent of patients saw a reduction in outpatient appointments but the proportion was less for patients who had been referred to funded VCS services (30 per cent).

Conclusion

Overall, the analysis of patient-level Hospital Episodes Statistics reflects positively on the effectiveness of the Social Prescribing Pilot. There was a clear **overall trend that points to reductions in patients' use of hospital resources** after they had been referred to Social Prescribing. Furthermore, **patients who had been referred on to VCS services funded by the Social Prescribing Pilot had generally experienced greater reductions** than those who either declined a service or were referred to 'mainstream' statutory or VCS provision instead.

At this stage these findings should be viewed positively, particularly in light of the consistent patterns identified, but also with some caution: there were too few patients in the sample analysed (in the case of the 12 month sample) and too little time had elapsed (in the case of the six month sample), to produce findings that are statistically significant. Plans for future analysis are outlined in the following section.

4.3. Future analysis of Hospital Episode Statistics

Analysis of Hospital Episode Statistics will be undertaken in subsequent years. This will aim to build on the existing analysis in a number of ways:

- analysis of additional patient cohorts
- analysis of a longer time series

- development of a robust control group
- incorporation of data on use of social and residential care.

The overall aim will be to generate data that enables more robust and statistically powerful analysis. This is discussed in more detail below.

Additional patient cohorts

The current analysis focusses on two early cohorts of Social Prescribing patients and their utilisation of hospital resources. Over time more patients will be added to these cohorts and the impact of Social Prescribing on different cohorts compared. For example, it may be possible to compare the progress of patients referred at the beginning of the Pilot to patients referred in the later stages, to explore if impact has improved as Social Prescribing processes and the range of services available have been refined.

Analysis of a longer time series

At this stage it has only been possible to compare progress of patients at 12- and six months. As the evaluation progresses data over a longer time series will be available and analysis of the extent to which impacts improve or last will be possible.

Developing a robust control group

The use of a control or comparison group is important for estimating what might have happened in the absence of the intervention (the 'counterfactual'). It is particularly important in the context of interventions designed to reduce health service utilisation as the patients offered such interventions usually have previously experienced high levels of service use. Such patients have a natural tendency to show reductions in service use over time, even in the absence of a specific intervention.⁸ This is due to a statistical phenomenon called 'regression to the mean'. Although the Social Prescribing Pilot involved selecting patients on the basis of a predictive model that seeks to take account of this phenomenon, reductions in service use over time are nevertheless possible and should be accounted for.

The gold-standard approach to selecting a control group is the randomised controlled trial. This is because randomisation has the potential to balance both observed and unobserved characteristics between different groups.⁹ For this evaluation, however, it has only been possible to evaluate the effect on patients who had already received the intervention. Other similar studies¹⁰ have used large administrative data sources to select control groups of patients that appeared similar to their intervention group patients in the period prior to the start of the intervention, but who did not receive the intervention themselves.

At this stage, and primarily due to the limits of the resources available for the evaluation, such a control group has not been established. We have instead explored the progress of two different groups of Social Prescribing referrals: all patients referred to Social Prescribing from ICMTs, and a sub-sample of patients who received an onward referral to a funded voluntary sector service provider. The risk stratification tool used in the referral process sought to ensure that these two groups were reasonably similar at the point of referral but the analysis undertaken so far suggests there might be something inherently different about these two groups. A

⁸ Lewis, G et al (2013. *Impact of 'Virtual Wards' on hospital use: a research study using propensity matched controls and a cost analysis*. National Institute for Health Research

⁹ Ibid

¹⁰ Ibid

control or comparison group would help mitigate the effects of this difference in any future evaluation.

Going forward, the evaluation will explore the possibilities for accessing administrative data, for example through the Health and Social Care Information Centre (HSCIC), to develop a more robust external control group. This will enable the use of statistical techniques, such as propensity score matching, to develop a suitable control or comparison group.

Incorporating data on use of social and residential care

There is emerging evidence from the Pilot that being referred to Social Prescribing impacts positively on patients' use of social and residential care. This could represent a considerable saving to local authority spending on Adult Care Services but in order to assess the impact in full additional data would be required.

Social impact

This chapter draws on a combination of quantitative and qualitative data to provide an assessment of the social impact of the Rotherham Social Prescribing Pilot. Two data sources provide the basis for this assessment. First well-being outcome data, collected by the Pilot from patients, was analysed to identify progress against eight separate outcome measures linked to well-being and positive functioning. Second, five service level case studies, involving 17 interviews with Social Prescribing patients and carers, provided a more detailed insight into the range of social impacts associated with the Pilot.

5.1. Well-being outcomes

The Social Prescribing Pilot measured patients' progress towards social outcomes through a well-being measurement tool developed specifically for the service. The tool was completed by VCSAs with patients when they were first referred to the service (baseline) with progress measured after approximately three-four months (follow-up). It has eight measures associated with different aspects of self-management:¹¹

- **Feeling positive:** hope, learning to cope and feeling calm
- **Lifestyle:** sleeping habits, smoking, diet and exercise
- **Looking after yourself:** shopping, going out, transport and personal care
- **Managing symptoms:** energy levels, pain, information and medication
- **Work, volunteering and other activities:** new roles, volunteering and social groups
- **Money:** debt advice, benefits and managing money
- **Where you live:** heating, local facilities, stairs and fire safety
- **Family and friends:** isolation, carer support.

An overview of this outcome data is provided in Table 5.1 with more detailed analysis discussed in the sections that follow.

¹¹ 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.

Table 5.1: Overview of well-being outcome baseline and distance travelled data

Outcome area	Baseline			Distance travelled			
	Count	Mean	Low scores* (per cent)	Count	Mean	Progress made	
						All (per cent)	Low scores (per cent)
Feeling positive	819	3.08	30	280	3.62	35	61
Lifestyle	819	3.39	19	280	3.78	25	65
Looking after yourself	819	3.58	14	280	3.93	24	60
Managing symptoms	819	3.43	18	280	3.65	21	57
Work, volunteering and social groups	819	2.49	45	280	3.15	49	54
Money	819	4.05	10	280	4.39	21	76
Where you live	819	4.07	8	280	4.39	20	78
Family and friends	819	3.71	13	280	3.83	27	69

*A low score is defined as a baseline score of 2 or less

Baseline analysis

Between September 2012 and January 2014 baseline data was collected for 819 patients who were referred to Social Prescribing. In summary this baseline data shows that:

- **Feeling positive:** the average score was 3.1; 30 per cent of patients recorded a low score (of two or less)
- **Lifestyle:** the average score was 3.4; 19 per cent recorded a low score
- **Looking after yourself:** the average score was 3.6; 14 per cent recorded a low score
- **Managing symptoms:** the average score was 3.4; 18 per cent recorded a low score
- **Work, volunteering and other activities:** the average score was 2.5; 45 per cent recorded a low score
- **Money:** the average score was 4.1; 10 per cent recorded a low score
- **Where you live:** the average score was 4.1; 8 per cent recorded a low score
- **Family and friends:** the average score was 3.7; 13 per cent recorded a low score

This provides a useful insight into to social support needs of patients at their point of engagement with the Pilot. The lowest scoring outcome category was work, volunteering and other activities, followed by feeling positive, lifestyle, and managing symptoms. This highlights the importance of services that address psycho-social factors for people suffering from long-term conditions.

Distance travelled analysis

Of the 819 patients for whom baseline data had been collected 280 had been followed-up after three-four months. It is on the progress, or 'distance travelled', of these 280 patients that the remaining well-being outcome analysis focusses.

Overall, **83 per cent of patients experienced positive change** on at least one outcome measure. When the results are broken down by category it shows that progress was made against each outcome measure and that a majority of low scoring patients (with a baseline score of two or less) made progress:

- **Feeling positive:** 35 per cent made progress; of the patients with a low baseline score 61 per cent made progress
- **Lifestyle:** 25 per cent made progress; of the patients with a low baseline score 65 per cent made progress
- **Looking after yourself:** 24 per cent made progress; of the patients with a low baseline score 60 per cent made progress
- **Managing symptoms:** 21 per cent made progress; of the patients with a low baseline score 57 per cent made progress
- **Work, volunteering and other activities:** 49 per cent made progress; of the patients with a low baseline score 54 per cent made progress
- **Money:** 21 per cent made progress; of the patients with a low baseline score 76 per cent made progress

- **Where you live:** 20 per cent made progress; of the patients with a low baseline score 78 per cent made progress
- **Family and friends:** 27 per cent made progress; of the patients with a low baseline score 69 per cent made progress.

Statistical testing¹² was undertaken to explore the statistical significance of the proportion of Social Prescribing patients moving from a low baseline score to a high score (of 3-5) when followed-up. This demonstrated that the change was statistically significant for all but one outcome measure (managing symptoms). This provides a high degree of confidence that the outcome change observed represents real change, and did not occur due to random chance.

The distance travelled by Social Prescribing patients across a range of outcomes after a relatively short period demonstrates the potential of social interventions to address some of the key psycho-social determinants of health. That most progress was made against the lowest scoring outcome areas (work, volunteering etc.; and feeling positive); and that a majority of low-scoring patients made progress; reflects positively on both the effectiveness of the Social Prescribing assessment and referral process and the ability of commissioned services to meet the specific social needs of patients.

5.2. Case study findings

The Interim Report identified a number of examples of social outcomes for Social Prescribing clients that emerged during the early stages of the Pilot. These included:

- patients becoming more independent and able to access social prescribing activities with less intensive support
- patients becoming better at managing their long-term condition themselves
- patients and carers feeling less socially isolated and enjoying more social interaction.

These findings were identified through interviews with key stakeholders in the service such as GPs, social workers, VCS providers and commissioners. They provide an illustration of the types of outcomes and impact that might occur more widely as a result of social prescribing in the longer term. Since the publication of the Interim Report five in-depth case studies have been undertaken with services funded through the pilot. Through qualitative interviews with individuals delivering services (10 interviews) and beneficiaries of services and their carers (17 interviews), these case studies have provided more detailed evidence of social outcomes experienced by Social Prescribing patients. An overview of this evidence is provided in the following sections, grouped around the four broad outcomes of increased well-being, reduced social isolation and loneliness, increased independence, and access to wider welfare benefits. In addition, more detailed case study reports are provided in Appendix 1.

Improved well-being

Improvements in the well-being of patients accessing Social Prescribing services emerged very clearly as one of the most important and widely identified benefits of the Pilot. Service providers were particularly effusive about the wide ranging well-

¹² 95 per cent confidence intervals were applied. The McNemar test was applied to identify statistically significant change between baseline and follow-up outcome scores for each outcome category

being benefits they felt beneficiaries experienced and some specific examples of these benefits were identified through the interviews with patients and carers.

Improvements in mental well-being were particularly evident from the case study interviews. Mrs A welcomed the opportunity to meet people and interact by attending a sensory arts group, and saw it as a "lifeline" in her battle with anxiety and depression:

"If it wasn't for the group, I might not be here now because I'd been that down and depressed....just getting out of the house has helped me with the fear, anxiety...talking to people lifts your mood and forget about problems at home".

Similarly, Mrs B felt that attending a variety of groups and activities funded through the Pilot had *"got her out of her depression"* and Mrs C reflected that the activity she attended *"makes us feel worthy instead of worthless...feeling less depressed"*.

Confidence was another aspect of well-being in which Social Prescribing beneficiaries saw improvement. Previously, Mrs C found it difficult to talk to new people, but over time she felt she had become more confident whilst attending a group and felt more able to play an active role.

"We talk about various things, about what we're doing, and how you're feeling".

For other beneficiaries a more general sense of positive well-being was evident. Prior to her referral to Social Prescribing, Mrs D *"was completely stuck"* and *"didn't know who to go to and what to do"* but she subsequently felt *"a little better"* within herself.

For carers, time and space away from their caring duties was particularly welcome, and had a wide range of well-being benefits. For example, prior to her referral to Social Prescribing Mrs E wasn't able to leave her husband and get out of the house for more than an hour at a time and was *"physically and emotionally exhausted"*, but the additional support had alleviated the pressure somewhat.

Reduced social isolation and loneliness

A further benefit of accessing Social Prescribing services, and linked to beneficiaries' well-being, was a reduction in social isolation and loneliness. Service providers highlighted the importance of linking people with limited mobility and social contact with the wider community. This was also highlighted in the interviews with beneficiaries. For example, when she was referred Mrs C didn't expect to get anything out of Social Prescribing but has since realised that she now does not feel as isolated and was *"just looking at four walls without the service"* and noted *"while you're here you don't think about your health conditions, you just get on with it"*. Similarly, Mrs F, who received re-abling and befriending support through Social Prescribing, valued the additional high quality social contact it provided.

"It's someone coming to talk to me and with me and they acknowledge me...because you can sit and stare at space and people take no notice whatsoever...I feel like I belong to a society".

Sometimes, activities to reduce isolation and loneliness had wider benefits in terms of community engagement and involvement. In one example, Mr A had had a number of strokes and spent a lot of time at home. Through Social Prescribing he was able to get involved in volunteering, supporting an older peoples indoor bowling group, three times a week. This *"got him out of the house"* and he *"enjoyed it, just getting out the house for a few hours, sommat to do"*.

Increased independence

Increased independence was also identified by service providers and beneficiaries as an important benefit of Social Prescribing. In particular, those with limited mobility were able to become more independent as a result of improvements in their physical health. For example, Mr B had suffered a severe stroke three years ago, which affected his mobility and his speech, and was told his health may never improve. After being referred to Social Prescribing Mr B started going to a gym once a week, and participated in activities at the community centre, including creative writing, on several other days. Since receiving support through Social Prescribing Mr B had become more independent and positive.

"I was on my own, I was totally on my own...each day I'm getting better and better...before I could hardly walk...I'm feeling very positive, each day I get up and I just can't believe how much I've come on".

Similarly, Mrs G was referred to an exercise class and her mobility improved significantly. As a result she had *"regained some independence"*, and felt better physically and emotionally because she had *"something to look forward to"*. Without Social Prescribing, Mrs G believed she would withdraw within herself and become isolated again.

There have also been examples of beneficiaries becoming involved in independent social and community action since accessing Social Prescribing services. Mrs A, for example, from taking tentative steps when accessing Social Prescribing services for the first time, has become a proactive member of the group and has produced a Facebook account for the group to display their artwork. Linked to this, Mrs B reported examples of self-help and mutual aid within the group she attended, with members doing shopping for each other when carers or family members have been unavailable. Mrs H, who cares for her partner, provided similar reflections.

"I can go out and I've got peace of mind and I know he's alright and he's safe and there's somebody with him...I feel better".

Access to wider welfare benefits

A final area of outcomes associated with access to Social Prescribing services was the ability of beneficiaries to access wider welfare benefits. The role of advocacy services was particularly important in making beneficiaries and their carers aware of various benefits that could be available to them and supporting them to make applications. For example, Mrs D has literacy problems and her benefits were stopped at short notice. Through Social Prescribing she was able to access an advocate who helped her complete benefit forms and to apply for a free bus pass. Similarly, Mrs G and her family were supported to apply for Direct Payments to increase the frequency of the carer support available to them. For Mrs D and Mrs G, gaining access to these benefits and the wider support they enabled was key to their subsequent realisation of other outcomes, such as improved well-being (in the case of Mrs D) and independence (Mrs G).

6

Economic and social cost-benefits

This chapter provides a monetised assessment of the economic and social cost-benefits of the Social Prescribing Pilot. The economic cost-benefits are estimated based on analysis of the Pilot's effect on patients' use of hospital care (Chapter 4). Social cost-benefits (social value) are estimated based on analysis of the Pilot's social impact (Chapter 5), using well-being outcome data and information about volunteers, welfare benefit claims and additional funding access, collected through a survey of funded VCS providers.

6.1. The costs of the Social Prescribing Pilot (inputs)

Overall the Social Prescribing Pilot cost £1,099,792. A more detailed breakdown is provided in Table 6.1

Table 6.1: Overview of Social Prescribing Pilot Costs (2012-14)

	Year 1 (Apr 12-Mar 13)	Year 2 (Apr 13-Mar 14)	Total
Grants to Providers	£301,727	£204,540	£506,266
Additional Support Grants	£11,265	£93,066	£104,331
VAR costs (salaries/overheads etc.)	£216,182	£273,012	£489,194
Total	£529,174	£570,618	£1,099,792

These costs provide the basis for the social and economic cost-benefit analysis that follows in this chapter. They represent the direct costs (inputs) of commissioning the Pilot to the CCG. However, it should be noted that a range of other indirect costs (inputs) have been borne by different stakeholders in the pilot:

- **Voluntary Action Rotherham and the CCG:** invested a significant amount of time prior to the commissioning of the pilot to research need for the service, develop the service model and specification, and consult with GPs and voluntary sector organisations.
- **The Foundation Trust:** supported the development of a complex client management system (database) through which referrals in to and out of the service were monitored and reported on. Support for the maintenance of this system is ongoing.

- **Volunteers:** many of the services provided through the Pilot were provided with considerable support from volunteers. They input their own time, without which the direct costs of delivering the Pilot would have been far higher. The value of this time input is discussed later in this chapter.

Although these costs have not been calculated and included in the cost-benefit analysis, it is important that they are considered alongside direct monetary costs.

6.2. The economic benefits of the Social Prescribing Pilot

This section considers the economic cost-benefits of the Social Prescribing Pilot. Three types of NHS cost are considered:

- hospital admissions (inpatient stays)
- Accident and Emergency attendances
- outpatient appointments.

Methodology

Activity was costed using the 2013/14 Payment by Results (PbR) national tariff.¹³ In cases where the activity did not have a tariff, costs were estimated from the NHS reference costs.¹⁴ These tariffs represent the cost to the commissioner of care, rather than the actual costs of providing care. This approach to costing is consistent with a number of studies undertaken for the NHS Institute for Health Research.¹⁵

The costs of inpatient admissions were established by calculating the Healthcare Resource Group (HRG) for each patient's whole stay in hospital. The PbR rules were used to combine the HRG, admission type and other details of the hospital stay. This included the unit cost of the HRG, including where the reduced short stay emergency was applied and payments were due because of an unexpectedly long stay in hospital (i.e. where the tripoint was exceeded). Accident and Emergency costs were also calculated as recommended by the PbR rules, with outpatient costs derived from NHS reference costs.

Following the calculation of costs, analysis was undertaken on similar basis to that presented in Chapter 4. For the 12 month sample the cost of each type of episode was compared for the 12 month periods before and after referral to Social Prescribing. For the six month sample the costs of the six month periods before and after referral were compared.

Cost comparisons

An overview of the cost comparisons is provided in Tables 6.2 and 6.3. Comparisons are provided for each type of hospital episode and for the total costs associated with all episodes. As in Chapter 4, figures are provided for all referrals to Social Prescribing and the sub-group of patients who were referred on to a funded VCS provider.

¹³ NHS PbR guidance is available online at:

<https://www.gov.uk/government/publications/payment-by-results-pbr-operational-guidance-and-tariffs>

¹⁴ NHS Reference Costs are available online at <https://www.gov.uk/government/collections/nhs-reference-costs>

¹⁵ See for example: Lewis, G et al (2013). *Impact of 'Virtual Wards' on hospital use: a research study using propensity matched controls and a cost analysis*. National Institute for Health Research

Table 6.2: Per-patient utilisation of hospital resources: cost comparison - 12 month cohort

	All patients referred to Social Prescribing			Patients referred to a grant funded VCS provider		
	12m before	12m after	Change	12m before	12m after	Change
Cost of inpatient admissions	£2,633	£2,434	-£198	£2,282	£2,001	-£281
Cost of A&E attendances	£201	£174	-£27	£221	£183	-£38
Cost of outpatient appointments	£184	£145	-£39	£206	£147	-£59
Total cost	£3,018	£2,753	-£265	£2,708	£2,330	-£378

Table 6.3: Per-patient utilisation of hospital resources: cost comparison - six month cohort

	All patients referred to Social Prescribing			Patients referred to a grant funded VCS provider		
	6m before	6m after	Change	6m before	6m after	Change
Cost of inpatient admissions	£1,112	£1,098	-£14	£1,058	£896	-£162
Cost of A&E attendances	£81	£73	-£8	£82	£70	-£12
Cost of outpatient appointments	£80	£68	-£12	£78	£75	-£3
Total cost	£1,273	£1,239	-£34	£1,218	£1,040	-£178

Per-patient cost reductions have been identified in both cohorts but the cost reductions are considerably greater for the group of patients that had been referred on to a funded VCS provider:

- in the 12 month cohort there was an overall cost reduction of £265 per patient but the per patient cost reduction for patients referred to a funded VCS service was £378
- in the six month cohort there was an overall cost reduction of £34 per patient but the per patient cost reduction for patients referred to a funded VCS service was £178.

The total cost reduction figures for the 12 month cohort provide the basis for an estimate of the annual economic cost-benefits to the NHS presented in the following section.

Estimated cost-benefits

Annual cost-benefits were calculated through a two stage process to capture the fact that patients who were referred to funded VCS services demonstrated, on average, greater cost reductions than those who were not:

1. The cost-benefits associated with patients who were referred on to funded VCS provision were calculated: by multiplying the per-patient cost reduction for this sub-group (£378) by the total number of referrals to grant funded providers across each year of the pilot (Year 1=217; Year 2=901).
2. The cost-benefits associated with referrals to Social Prescribing who were not referred on to VCS provision were calculated: by multiplying the overall per-patient cost reduction (£265) by the remaining number of referrals to Social Prescribing across each year of the pilot (Year 1=208; Year 2=281).

The analysis therefore assumes that the cost reductions identified for the 12 month samples are representative of Social Prescribing as a whole, and that being referred to a funded VCS service is more beneficial than not being referred on. Table 6.4 provides an overview of the estimated annual cost reductions identified.

Table 6.4: Overview of estimated annual cost reduction associated with the utilisation of hospital resources

Patients referred to a grant funded VCS provider			Patients not referred to a funded VCS provider		
Per patient	Year 1 total	Year 2 total	Per patient	Year 1 total	Year 2 total
£378	£82,026	£340,578	£265	£55,120	£74,465

These values can be compared with the costs of delivering the Social Prescribing Pilot to provide an estimate of the annual return on investment provided (Table 6.5).

Table 6.5: Estimated annual return on investment (ROI) from NHS cost reductions

	Costs	Benefits			ROI
	Input costs	Patients referred to a grant funded VCS provider	Patients not referred to a funded VCS provider	Total	
Year 1 (Apr 12-Mar 13)	£529,174	£82,026	£55,120	£137,146	0.26
Year 2 (Mar 13-Apr 14)	£570,618	£340,578	£74,465	£415,043	0.73
All years	£1,099,792	£422,604	£129,585	£552,189	0.50

This demonstrates that the **estimated annual NHS cost reduction for the two years of the pilot was £552,189** compared to total input costs of £1.1 million. This translates to an annual return on investment of 0.50 (50 pence for each pound

invested). However, it is important to note that the Year 1 figures do not provide an accurate reflection of the likely cost-benefits of Social Prescribing over a longer period. This is because of the considerable time that elapsed between the commissioning of the Pilot and the first referrals-in (circa five months) and the first referrals-out (circa eight months). As such the number of referrals was far lower than in Year 2 of delivery which encompassed a full 12-month period. Therefore, when considering the likely cost-benefits that will occur during future years of delivery it would more realistic to use the figures for Year 2 rather than the combined figured for both years. This provides a much higher estimated annual return on investment of 0.73 (73 pence for each pound invested)

Using these figures as a basis for longer-term projections, and assuming that the benefits identified are sustained over a longer period, **the costs of delivering the service for a year could be recouped by commissioners after 18 to 24 months.** Table 6.6 demonstrates how these benefits might accumulate over a longer period (up to five years).

Table 6.6: Estimated long-term return on investment (ROI) from NHS cost reductions

	1: Benefits last for 5 years		2: Benefits drop-off at 20 per cent per year		3: Benefits drop-off at 33 per cent per year	
	Cumulative value	ROI	Cumulative value	ROI	Cumulative value	ROI
Year 1	£415,043	0.73	£415,043	0.73	£415,043	0.73
Year 2	£815,559	1.43	£735,456	1.29	£679,384	1.19
Year 3	£1,201,549	2.11	£967,050	1.69	£806,761	1.41
Year 4	£1,573,013	2.76	£1,115,636	1.96	-	-
Year 5	£1,929,950	3.38	£1,187,023	2.08	-	-

This shows that, for each year of full service delivery:

- if the full benefits last for five years they could lead to total cost reductions of £1.9 million: a return on investment of 3.38 (three pounds 38 pence for each pound invested)
- if the benefits are sustained but drop-off at a rate of 20 per cent each year they could lead to total cost reductions of £1.2 million: a return on investment of 2.08 (two pounds and eight pence for each pound invested)
- if the benefits are sustained but drop-off at a rate of 33 per cent each year they could lead to total cost reductions of £807,000: a return on investment of 1.41 (one pound and 41 pence for each pound invested).

6.3. The social benefits (social value) of Social Prescribing

This section considers the social cost-benefits, or social value, of the Social Prescribing pilot. It uses financial proxies to provide a monetised assessment of social impact arising from the pilot. Four aspects of social value are considered:

- the well-being benefits for Social Prescribing patients
- the volunteering associated with the pilot
- the additional welfare benefits claimed by Social Prescribing patients
- additional funding accessed by funded VCS services providers that can be attributed to their involvement in the pilot.

The value of well-being benefits

The approach to monetising well-being draws on social value work undertaken by the New Economics Foundation and New Economy Manchester¹⁶ to value the subjective well-being benefits associated with social interventions. Well-being is equated with mental health to enable the use of health economics to monetise the social value created. Analysis by the Centre for Mental Health¹⁷ 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 Clinical 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 Pilot did not use a recognised QALY-based social value 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.

It is important to note that measurement of subjective well-being is a relatively new discipline, and there have been relatively few attempts to value well-being. In particular, it is recognised that using mental health as a proxy for well-being may not be the most accurate way of determining the true value of well-being. Likewise the well-being outcome tool cannot be considered as accurate a measure of health-related quality of life as the validated tools used in health economics. As such the findings presented here should be considered experimental, and the methodology for valuing the well-being benefits of Social Prescribing will be refined as the project progresses.

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. In the first approach, 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 client progressing one point on an outcome measure accrued £264 of social value while a client progressing five points accrued £1,320. In the second approach outcome change was only valued for clients who progressed from a low score (of two or less)

¹⁶ Cox, J et al (2012) *Social Value: Understanding the wider value of public policy intervention*. New Economy Working Paper 008

¹⁷ Centre for Mental Health (2010). *The economic and social costs of mental illness*, (June 2003, updated October 2010)

to a high score (of three or more). In this approach a client 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 6.7.

Table 6.7: 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 patients in the Social Prescribing Pilot is provided in Tables 6.8 and 6.9. The total value was calculated by multiplying the per-patient value by the total number of referrals to grant funded providers across each year of the pilot (Year 1=217; Year 2=901).

Table 6.8: 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 patient value	Year 1 value	Year 2 value	Per patient value	Year 1 value	Year 2 value
Feeling positive	£139	£30,163	£125,239	£199	£43,183	£179,299
Lifestyle	£66	£14,322	£59,466	£69	£14,973	£62,169
Looking after yourself	£65	£14,105	£58,565	£93	£20,181	£83,793
Managing symptoms	£42	£9,114	£37,842	£31	£6,727	£27,931
Work, volunteering and social groups	£184	£39,928	£165,784	£214	£46,438	£192,814
Money	£80	£17,360	£72,080	£93	£20,181	£83,793
Where you live	£68	£14,756	£61,268	£49	£10,633	£44,149
Family and friends	£89	£19,313	£80,189	£75	£16,275	£67,575

Table 6.9: Overview of the estimated annual well-being value created by year

	1: Valuing all outcome change	2: Valuing low to high outcome change
Year 1 (Apr 12-Mar 13)	£159,061	£178,591
Year 2 (Mar 13-Apr 14)	£660,433	£741,523
All years	£819,494	£920,114

It shows that the two approaches to valuation provided very similar results: valuing all outcome change produced an estimated total annual well-being value of £819,000; valuing only low-to-high outcome change produced an annual value of £920,000. These values can be compared with the costs of delivering the Social Prescribing Pilot to provide an estimate of the annual return on investment provided (Table 6.10).

Table 6.10: Estimated annual return on investment (ROI) from well-being benefits

	Input costs	1: Valuing all outcome change		2: Valuing low to high outcome change	
		Total value	ROI	Total value	ROI
Year 1 (Apr 12-Mar 13)	£529,174	£159,061	0.30	£178,591	0.34
Year 2 (Mar 13-Apr 14)	£570,618	£660,433	1.16	£741,523	1.30
All years	£1,099,792	£819,494	0.75	£920,114	0.84

This demonstrates that the estimated return on investment from well-being benefits for the two years of the Pilot was between 0.75 and 0.84 (between 75 pence and 84 pence per pound invested). In Year 1, the estimated return on investment was between 0.30 and 0.34 (between 30 pence and 34 pence per pound invested) and in Year 2 it was between 1.16 and 1.30 (between one pound and 16 pence and one pound and 30 pence per pound invested). This means that in Year 2 of the Pilot the estimated well-being value created was greater than the input cost of delivering the service.

As with the NHS cost reductions, it is important to note that the Year 1 figures do not provided an accurate reflection of the likely social cost-benefits of Social Prescribing over a longer period. This is because of the considerable time that elapsed between the commissioning of the Pilot and the first referrals-in (circa 5 months) and the first referrals-out (circa 8 months). As such the number of referrals was far lower than in Year 2 of delivery which encompassed a full 12 month period. Therefore, when considering the likely social cost-benefits that will occur during future years of delivery it would more realistic to use the figures for Year 2 rather than the combined figure for both years. On this basis, **a positive social return on investment based on the well-being benefits experienced by patients would be achieved** during the first year post referral.

The value of volunteering

Volunteering was a key feature of the Social Prescribing Pilot. It is estimated that, overall, **81 volunteers each contributed an average of three and a half hours of their time per week** to services funded by the Pilot: this is the equivalent of around seven FTE employees. This contribution has considerable value that can be estimated based on the value of the input provided by volunteers:¹⁸ the amount that it would cost to pay employees to do the work carried out by volunteers.¹⁹ There are a number of hourly rates that could be used to estimate this value; these include: the national minimum wage, the local median wage, the local mean wage and the reservation wage. The latter, the hourly rate associated with the actual role of volunteers is the preferred option; however the data available does not enable an accurate calculation using this method. Therefore the preference in this study has been to provide a range using the national minimum wage²⁰ (low estimate) and the local median wage²¹ (high estimate). In reality the true value of the input provided by volunteers will lie between the two estimates.

On this basis, it is estimated that the annual value of volunteering undertaken during delivery of the Social Prescribing Pilot was worth:

- **£81,000** based on the national minimum wage
- **£148,000** based on the national median wage.

This represents an additional £0.14 - £0.26 (14-26 pence) for each pound invested in the Pilot by the CCG.

The value of additional welfare benefits

VCS service providers in receipt of funding through the Social Prescribing Pilot supported referred patients to claim an additional £350,000 in welfare benefits over the course of the Pilot. Benefits claimed included Attendance Allowance, Direct Payments, Carer's Allowance, Housing Benefit, Personal Independence Payment, and Employment Support Allowance. The case study evidence demonstrates that in many cases these patients would not have been aware of their entitlement to these benefits, or how to claim them, without the services, support and advocacy received through Social Prescribing.

The value of additional funding to VCS providers

Two VCS service providers in receipt of funding through the Social Prescribing Pilot were able to secure additional funding as a result of their Social Prescribing grant: one provider received £180,000 from the Big Lottery Fund (BLF), one received £10,000 from NHS England and another received £10,000 from Awards for All (BLF small grants fund). In addition, 11 funded VCS service providers reported that Social Prescribing patients had accessed additional services through self-funding or by using their Direct Payments or Personal Budgets: the value of this additional income was at least £10,000 over the course of the pilot.

¹⁸ This is the value of volunteering to the organisations providing funded Social Prescribing services and therefore the value of volunteering to the Pilot. It is the approach recommended by Volunteering England (now part of NCVO).

¹⁹ This assumes that there are no additional costs faced by organisations in using volunteers: for example extra management costs.

²⁰ £6.31 per hour from October 2013.

²¹ £11.56 in 2013 (the Annual Survey of Hours and Earnings provides a wide range of information on hourly, weekly and annual earnings of employees April 2013).

Conclusion

This report has provided a detailed assessment of the economic and social impact of the Rotherham Social Prescribing Pilot. It builds on an earlier Interim Evaluation report which identified emerging lessons from the Pilot and provided insights from the perspective of key stakeholders. This final concluding chapter draws together findings from both reports to provide an overall assessment of the Pilot and highlights some implications for future service delivery and commissioning. It discusses in turn:

- outcomes for Social Prescribing patients and their carers
- outcomes for the public sector
- outcomes for the local voluntary and community sector
- implications for future service delivery and commissioning
- next steps for evaluation.

7.1. Outcomes for Social Prescribing patients and their carers

The Pilot reached more than 1,500 local people with long-term health conditions. A large majority of these patients and their carers experienced positive health and well-being outcomes. Since being referred to Social Prescribing patients' and carers' mental health has improved, they have become more independent, less isolated, more physically active, and have begun engaging with and participating in their local community. They have also been able to access a range of welfare benefits that they were previously unaware of. Crucially, Social Prescribing services have provided these patients and carers with an important first step to engaging with community-based services and wider statutory provision that they would not otherwise have been aware of or able to access.

7.2. Outcomes for the public sector

Patients accessing the Pilot were already high users of hospital care and assessed as at high risk of accessing unplanned hospital care in the future: in the 12 months prior to referral Social Prescribing patients²² cost commissioners an average of £3,018 per client in inpatient stays, Accident and Emergency attendances and outpatient appointments alone; by comparison, the NHS Confederation estimated that the money spent per capita on all NHS services in England was £1,979 in 2010/11.²³ The importance of demonstrating the ability of Social Prescribing at reducing patients' use of hospital care can therefore not be underestimated and is regarded as an important measure of success by local NHS commissioners.

²² Estimate based on data for the 12 month cohort

²³ <http://www.nhsconfed.org/resources/key-statistics-on-the-nhs> Last accessed 15 July 2014

So far the evaluation evidence is very positive. Social Prescribing patients' use of hospital resources, measured through the number of inpatient stays, Accident and Emergency attendances and outpatients appointments, reduced by up to fifth in the 12 month period following their referral to Social Prescribing. This translates into potential positive financial returns to commissioners in a relatively short period following the initial referral. However, at this stage these findings carry an important caveat: there are too few patients analysed and too little time has elapsed to produce findings that are statistically significant. In 12 months' time it will be possible to produce more statistically robust evidence, as a larger number of patients will have been tracked over a longer period.

In addition to these direct health related resource and cost benefits, the public sector has experienced broader outcomes as a result of the Social Prescribing Pilot. For example, patients accessing the service are generally more satisfied with the support they received and feel better supported to manage their condition. Furthermore, there is emerging evidence that non-health services, in particular social and residential care, benefit from similar reductions in resource utilisation and service delivery costs. However, detailed analysis of social care data would be needed to properly quantify the extent of these reductions.

7.3. Outcomes for the local voluntary and community sector

Although not an intended direct beneficiary of the Social Prescribing Pilot, the local voluntary and community sector (VCS) has also benefitted. For example, the £0.6 million that was invested in VCS Social Prescribing services has been a catalyst for innovation in community-level service provision, enabling small organisations without a track record in health service provision to access NHS funding for this first time. Some of these providers have been able to 'match' their Social Prescribing with income from other sources, including National Lottery grants, public sector contracts, Direct Payments and self-funders, to enhance their provision and improve the overall sustainability of their organisation. Overall, the Pilot has demonstrated the potential for relatively small community-based provision to make a positive and cost-effective contribution to local strategic health and well-being priorities, and ought to provide a strong foundation for these types of providers to continue making a positive contribution through commissioned services in the future.

7.4. Implications for future service delivery and commissioning

The Social Prescribing Pilot and the evidence collected as part of the evaluation, have some important implications and lessons for future public service delivery and commissioning involving the VCS in health, social care, and more broadly.

Demonstrating social value through commissioning

Under the provisions of the Public Service (Social Value) Act 2012²⁴ statutory bodies are required to consider during commissioning and procurement '*how what is proposed to be procured might improve the economic, social and environmental well-being of the relevant area*', and, '*how, in conducting the process of procurement, it might act with a view to securing that improvement*'. This evaluation has demonstrated the types of social value that can be created through public services commissioned through the VCS. These include reductions in the utilisation (and ultimately cost) of public services, improvements in the health and well-being of local people, independent community engagement and social action, wider economic

²⁴ See <http://www.legislation.gov.uk/ukpga/2012/3/enacted> for the full wording of the Act

benefits in the form of welfare entitlements and funding, and a more sustainable, vibrant and innovative local VCS. It is important to note that this social value is accrued by a range of different stakeholders (not just commissioners and beneficiaries) and is not always a direct aim of the service that has been commissioned. Therefore, as local statutory bodies implement the Act going forward, they should be encouraged to consider the social value that could accrue for a range of different stakeholders in the service being commissioned, and ensure that this is embedded in procurement processes.

The role of local infrastructure in micro-commissioned community services

The central role played in the Social Prescribing Pilot by the local VCS infrastructure organisation, Voluntary Action Rotherham (VAR), has come through very clearly through the evaluation. First, VAR played a key role in getting the Pilot up and running through strong partnership working with the NHS PCT/CCG and local VCS organisations, building on relationships, trust and understanding that had been developed over a number of years. Second, VAR has been the accountable body (or prime contractor) responsible for delivering the Pilot on behalf of the CCG. This has included developing the Social Prescribing 'model' enacted in Rotherham, establishing the systems and processes necessary for the pilot to function effectively, and micro-commissioning the community services required to deliver the Pilot.

Commissioners, health and care professionals and VCS providers have been overwhelmingly positive about VAR's role in delivering the pilot. In particular they have valued VAR's professionalism, independence, adaptability and, perhaps most importantly, their knowledge and understanding of the VCS in the borough and how its potential could be unlocked to deliver the Pilot effectively. As a result, the Pilot provides a model for future 'micro-commissioning' of community level services across a wide range of public service areas.

7.5. Next steps for evaluation

This is the final output of the Evaluation of the Social Prescribing Pilot but it has clearly demonstrated that the role for evaluation within the Pilot should continue if the long-term benefits of the investment in the service are to be fully understood. Ongoing evaluation will need to track Social Prescribing patients for a longer period post referral. Although patients need to be tracked for a minimum of 12 months post referral to identify the immediate benefits of Social Prescribing, there is also merit in tracking patients for a longer period (at least 2-3 years) to understand the extent to which benefits drop-off, are sustained, or are enhanced. In addition, the development of a control or comparison group would improve the statistical reliability of any data analysis and should be a priority for future evaluative work.

Appendix 1: Case Studies

Case Study 1: Crossroads Care

Organisation

Crossroads Care is a registered charity and a network partner of the Carers Trust. The organisation was established in 1990 in Rotherham and its main role is to provide support to carers, which (apart from complementary therapies provision) takes place in the client's own home. Support is tailored to the individual family; this involves a home visit and a discussion with the carer and the person they care for, and attempts are made to closely match staff with the carer's needs because support is usually provided over a long period of time. A dementia service and an end of life service are also provided, funded through NHS Rotherham CCG. Although Crossroads Care is part of the voluntary and community sector, all staff are fully trained and paid.

Services provided through Social Prescribing

The service provided through Social Prescribing benefits particular types of carers: the majority are supporting somebody with dementia. Although most carers want a respite service, long-term funding for intensive support is limited, so Crossroads have developed an alternative model to support carers. Although a small amount of respite is available, the new model focuses on teaching people to manage better through a programme of training and stress reduction, as well as respite. A menu of options is available for carers, which includes:

- **flexible respite** (30 hours over an eight week period)
- four **complementary therapy** sessions
- various **training options** such as 'Moving & Handling', 'Health & Safety' and 'Caring with Confidence' training
- **information and signposting**
- a **coffee morning** to bring carers together is also being set up.

This model of provision differs from their usual services because it is short-term and the aim is to help carers develop skills and capacities to manage and cope in their caring role, as well as providing some respite.

Patient case studies

Mrs A

Mrs A is 76 years old and lives with her husband, for whom she is a full-time carer. He was diagnosed with dementia 7 years ago and since then his health has deteriorated rapidly. As a result, he struggles with: his mobility; memory; his breathing; feeding himself; and sleeping. He is restless, frustrated, prone to falls and injuries, and Mrs A struggles to gain his cooperation for the sake of his own safety, *'He doesn't want to sit; he's up and down, up and down'*. She has been providing him with round-the-clock care and supervision. Her son helps out occasionally and her daughter takes her out from time to time. The care she receives through Social Services doesn't meet her needs adequately; some carers arrive when Mrs A has done the difficult task herself, for example, getting him ready for bed. She likes reading and researching places of interest on the internet, but has very little time to devote to these activities. Her husband's needs precede her own needs, for example, she booked an appointment at a Well Woman clinic which was cancelled when her husband suddenly went into hospital.

A GP at the memory service referred Mrs A to Crossroads Care in August; a risk assessment was undertaken and a care plan was produced based on Mrs A and her husband's needs. As well as providing support and advice, a carer was matched to the household's needs. Since then, respite care is usually provided for four hours once every week to allow Mrs A time to herself, and this has meant a lot to her *'because I can go out'*. Usually, a total of 30 hours of respite care is provided through the Social Prescribing service but this was extended in Mrs A's case because she clearly needed more support. Without the Crossroads service, she wouldn't be able to get out for more than an hour at a time

Mrs B

Mrs B is 72 years old and lives with, and provides care for, her partner who has Alzheimer's. Apart from attending day care once a week, the burden of his care has fallen on Mrs B and this has left her feeling isolated and *'a bit lost'*. She has very limited support from family. She used to go to art and cake decorating classes before Mr B got ill, to get out and socialise, but it isn't possible anymore, *'I don't matter really, I feel like that'*.

Her GP referred her to a VCSA who then referred her to Crossroads Care after assessing her needs. They undertook a risk assessment and produced a care plan based on Mrs B and her partner's needs. A carer was matched with the family, who visits once a week and occasionally, twice a week. The Social Prescribing service provides 30 hours of respite care over 8 weeks and there is some flexibility in the service in that patients can request a break, and then continue. In addition to referring her for respite, her GP also arranged for Mr B to attend a memory clinic.

The communication between Mr B and the Crossroads carer is good. A male carer is more suitable for Mr B, as he can be aggressive at times. Having the same carer and the familiarity helps build trust and a mutual understanding. The Crossroads respite care *'means a lot really. I can go out and I've got peace of mind and I know he's alright and he's safe and there's somebody with him'*. *'I feel better'*. Mrs B tries to coordinate her visits from the Crossroads carer with her regular hospital appointments, which she has for the treatment of a liver condition. Although the Social Prescribing service has not reduced her use of GP/hospital visits, this crisis support has clearly been important and could prevent the requirement for medical intervention in the longer term. *'A few weeks ago I did come to a boiling point. One thing had happened after another and I thought that's just finished me off'*. She rang Crossroads and they put her in contact with an organisation, for a week of emergency respite care. Crossroads also provided her with information about coffee

mornings and complementary therapies for some rest and relaxation.

Mrs C

Mrs C is 61 years old and lives with her partner. She has been providing care for her father, at his home (1.5 miles away), on a daily basis since April 2013. He has Alzheimer's and is partially sighted. Initially, Mrs C's father had two two-hour carer sessions per week provided by Social Services, which were withdrawn, and he also had four 30 minute visits per day and these have been cut down to four 15 minute visits, so his care has been reduced significantly. This has had a significant impact on Mrs C because she has to be more readily available to provide support. She does the washing; cleaning; shopping; takes him to his medical appointments; to the barbers; takes him to draw his pension; she handles all his financial affairs and pays his bills. *'It makes me tired, it makes me worried, it makes me feel guilty at times....trying to fulfill two roles, and you tend to put yourself last'*. She has lost weight; feels exhausted; stressed; tearful; and feels frustrated. This has affected: her relationship with her partner; her diet, because she doesn't cook anymore and only eats ready meals; her personal care due to a lack of time; and her ability to look after her own health.

There are no other family members to help out, so Mrs C sought help, this involved making numerous phone calls and leaving messages, *'spending hours and hours trying to find out where I could go to get any sort of help from, to me if there's a central point whose got that information readily available they can come and say to you this might suit you, or that might suit you'*. Eventually, she was referred by her GP to a VCSA. The Crossroads Care Coordinator *'came and gave us the opportunity to say what we would like, so we got the 30 hours of respite care'*. The respite care alleviated some pressure, *'but then the unfortunate thing is, it comes to an end and what do you do when it comes to an end?'* Without this service, Mrs C would have to dedicate most of her time, every day, to care for her father because he is so dependent and needs practical care as well as requiring company because he is lonely.

The Crossroads Care service offers Mrs C consistency by sending the same person every time, *'my dad got to know x, he liked him coming, they got used to each other, he felt comfortable with that'*. Through social prescribing, her father has accessed the Rotherham United Community Sports Trust for gentle exercise at home, the organisation Sense for arts and crafts, and the Royal Voluntary Service befriending scheme. Through Crossroads Care, Mrs C was also able to benefit from four massage sessions, which were therapeutic, *'you do feel as though you've come down, you lose the tightness that you carry around with you permanently'*.

Case Study 2: Age UK Rotherham

The organisation

Age UK Rotherham is an independent charity whose objective is to make the lives of older people in Rotherham as fulfilling and rewarding as possible. The organisation was established in 1978 and its main role is to provide a diverse range of services for older people including: hospital aftercare; domestic service; gardening; handypersons service; advice and information; a re-ablement service; security protection; befriending; and a social centre provided in the community.

Services provided through Social Prescribing

The social prescribing services provided by Age UK mainly support older people (over 55) who are socially isolated:

- a **reablement service**, based on the organisation's existing hospital aftercare service, aims to prevent readmission, preventing visits to GPs and district nurses. This involves an assessment of day-to-day activities such as washing and dressing; if an individual is struggling with a particular problem, they are supported to regain their independence.
- a **befriending service** utilises volunteers to support older people feeling lonely and isolated. Volunteers visit an individual they have been matched with on a regular basis to build up a relationship and help build confidence and promote some independence. Ten visits per person have been funded by Social Prescribing.
- **advice and information** is also offered to patients referred to Social Prescribing; benefit checks are undertaken during home visits and support is provided to complete forms.
- a **'Linkline' service** is also available; this is a telephone support service for lonely older people. Volunteers telephone vulnerable people (over 55) each morning to see how they are. This provides carers with support as well, knowing that the individual they care for has had a reassuring call each morning.

Patient Case Studies

Mrs A

Mrs A is a 93 years old and lives alone. She has a gardener, a lady who does her housework, a lady who gives her a shower twice a week, somebody who takes her out shopping and a Falls Prevention team, which the re-abling team referred her to, visits. She has various long-term health conditions; rheumatoid arthritis, thyroid, stomach problems, macular degeneration (gradual loss of vision), & mobility problems. Her health substantially restricts what she can do in terms of household domestic tasks and her general care. She doesn't see her family and friends as often as she would like; a close friend visits fortnightly. She enjoys listening to opera and attending the social centre at Age UK.

Mrs A said she liked the bi-weekly home visits made by the re-abling team. *'It's someone coming to talk to me and with me and they acknowledge me...because you can sit and stare at space and people take no notice whatsoever'*. She is also provided practical help, for example, to turn on the television, opening tins, and even being assisted to do mild exercises. As the team could not re-able Mrs A, her home visits were reduced to one per week and she was referred to the befriending service. *'I feel like I belong to a society'*. A number of interventions have been made to avoid slips and falls, for example, she was bought new slippers and shoes because because her footwear was too big and a handyperson was sent out to fix her toilet seat. Mrs A feels more positive than before Age UK got involved in her life.

Mrs B

Mrs B is 93 years old and housebound. She has a cleaner, who visits daily and a carer who visits every morning, at lunchtime and at bedtime. A mobile library service has also become available, which is handy as she enjoys reading. Mrs B has a number of long-term health conditions; painful knees which have to be washed and bandaged by a nurse twice a week. She recently had an operation on her hands for Carpal Tunnel Syndrome and when she went into hospital two years ago (for six weeks) with a clot on her lungs, they found that she also had an enlarged heart and irregular heartbeat. She never goes out unless family members can take her. She rarely sees her family and recently lost her close friend, and since then she has felt lonely. A befriender through Age UK, part of the social prescribing service, has been visiting her once a week. Her befriender has offered to take her out, but she isn't keen, she'd rather stay at home and have company. It's *'just somebody to natter to for a while'*. She felt this relieved some of her loneliness. Through the Social Prescribing service, Mrs B is entitled to 10 visits, free of charge, but to continue after this, she has to pay a fee of 3 pounds per visit, which Mrs B has recently started doing.

Mrs C

Mrs C is 63 years old and lives at home with her husband, for whom she is a carer. Her daughter helps when she visits once a fortnight. Her friends tend to visit once every two-three weeks. She has limited hobbies due to her health conditions, which include polio, arthritis, and poor mobility. Mrs C struggles to do household jobs. Recently, she saw her GP and has visited her district nurse 2-3 times, and she was admitted to Accident and Emergency in October. Since Age UK got involved through the social prescribing project, she has received considerable support, including Occupational Therapy; access to a mobility scooter and confidence building to use it; as well as a carer's assessment for her husband. She thinks *'more people should know about the service...things have got better since the Age UK visits'*.

Case Study 3: Kimberworth Park Community Partnership

Organisation

Kimberworth Park Community Partnership (KPCP) is an umbrella organisation for individuals and groups involved in running activities in the Kimberworth Park area. The partnership is based at the Chislett Youth & Community Centre through which a range of services and activities for children and families, younger and older people are developed and delivered. The Chislett Centre is an important community resource, providing a low-cost community gym and rooms that can be hired for local community events and activities.

Services provided through Social Prescribing

Unlike other Social Prescribing services, which receive referrals from a Voluntary and Community Sector Advisor (VCSA), KPCP receive referrals directly from the Integrated Case Management Team (ICMT). Following referral the KPCP Project Coordinator makes a home visit to carry out an initial assessment following which patients are referred to local neighbourhood services, including: the community gym, gardening project, befriending, luncheon club, financial inclusion support, massage/pamper sessions, fitness groups, social groups, employment advice.

Patient case studies

Mrs A

Mrs A is 75 years old, and lives alone. A cleaner visits twice a week and a gardener once a week. She sees one of her sons two/three times a week and another son who lives further away, two/three times each year. A close friend used to visit every week, but can't anymore because she is unwell. Mrs A is an avid reader, but can't pursue other hobbies due to her mobility problems. She had a heart attack earlier this year, and she has had a hip replacement. Four years ago she suffered a stroke which led to partial paralysis and affected her day-to-day life, *'I can't do anything that I used to do before'*. Her general well-being declined. Since accessing activities through the Social Prescribing service she has started to feel a lot better, *'at least I'm not getting up in the morning and thinking, when's it time to go back to bed. I can get out and keep myself doing something, which is brilliant'*. She attends an arts and craft session and a creative writing group at the centre each week, which she found out about from the KPCP Project Coordinator, and a chair exercise class (not part of the SPS). *'The creative writing gives me a chance to keep me brain going....because if I'm in the house all I do is sit and watch telly all day because I can't stand and do things'*. Mrs A relies on community transport due to her mobility problems.

Mrs A's GP referred her to the social prescribing service and consequently, the KPCP Project Coordinator did a home visit, *'I didn't want to go anywhere, where all they did was play bingo'*. She is pleased that her doctor considered an alternative for her, instead of medical intervention. She wanted companionship because she was lonely sitting at home and needed something to get her out of her depression, for which she was receiving medication.

Mrs B and Mr C (son of Mrs B)

Mrs B is 65 years old and has severe arthritis, and mobility problems. Her husband, Mr B, is 73 years old. He has had multiple strokes. Their son, Mr C, is 28 years old and has responsibility for the care of both his parents, which involves, cleaning, shopping etc. A VAR Voluntary Community Sector Advisor (VCSA) and the KPCP Project Coordinator visited the family at home as a result of GP referral. They did an initial assessment and talked to the whole family at the same time, using a household approach to support them. They learned that the household only received respite care two afternoons each week for Mr B through social services, so they arranged Social Prescribing service sessions for Mr B at the Rotherham United Community Sports Trust once a week, and he was referred to the Crossroads Care sit-in service, giving Mrs B time to get out and about. Mrs B has been to a couple of Social Prescribing service pampering, and arts and crafts sessions.

In addition, the Project Coordinator got Mr C involved in volunteering, supporting an older peoples indoor bowling group, three times a week to get him out of the house, *'I've enjoyed it, just getting out the house for a few hours, sommat to do'*. It has been difficult for Mr C to live with his father's dementia and his frustration, which he has sometimes taken out on his family, consequently, affecting Mr C's confidence. The Project Coordinator involved Mr C in volunteering to *'widen his access to other opportunities'*. Mrs B feels better emotionally because she *'has something to look forward to'*.

Mrs D

Mrs D is 86 years old and is hard-of-hearing. She lives alone in sheltered accommodation for old people, which is monitored by a warden. Her daughter visits once every three weeks and her son visits fortnightly. All of her friends have passed away. She feels lonely, particularly during the dark, colder months. She enjoyed reading, but her sight is so poor that she cannot do this anymore, so she spends most of her time watching television. Mrs D has heart problems, and is on a lot of medication for various long-term conditions. She struggles with her mobility, but makes an effort to walk to her local shop on most days. She can only do minimal housework, so a cleaner visits once every fortnight.

Following an initial assessment Mrs D decided to give the arts and crafts sessions a try. She is dependent on community transport to get to the centre. Over time, she has got to know a few of her group, *'I feel a bit better...when I come here, I'm alright'*. She has a purpose and something to talk to her family about when they visit. The Social Prescribing service hasn't had any impact on her use of health services, but without the service she says she would be, *'lost, I wouldn't know what to do'*.

Mr E

Mr E is 54 years old and lives at home with his wife and son. He suffered a severe stroke three years ago, which affected his mobility and his speech. Before this, he had an active lifestyle; he enjoyed cricket and football but couldn't play anymore. His wife contacted the Project Coordinator for support to get him active and involved. Within a week of his assessment Mr E had started going to a gym session and was provided with transport to get to the centre.

He attends the gym one day and creative writing on the other. He also goes out for pub meals. As a result of receiving support from the Social Prescribing service, Mr E has become more independent and positive, *'I was on my own, I was totally on my own'*. Since going to Chislett, his mobility has improved. Before Chislett, he felt very low, but now he is getting better. *'Each day I'm getting better and better...before I could hardly walk'*. He was told that his health would never improve, but the Social Prescribing service has made a huge difference, *'I'm feeling very positive, each day I get up and I just can't believe how much I've come on'*.

Case Study 4: Sense

Organisation

Sense is a national charity which works with people who are deaf and/or blind, and or experience other sensory impairments, providing support and services to assist people who are deaf or blind to live fulfilling and independent lives. They typically receive referrals from social services and health professionals, as well as the Social Prescribing service. A diverse range of activities and services are provided including: daily living skills, opportunities for voluntary work, arts and crafts, swimming, gym use, shopping, and eating out. The resource centre has a sensory room, computers and sound beam, and a ball pool.

Services provided through Social Prescribing

Funding from the Social Prescribing Pilot provides sensory art and craft sessions for 8 to 10 people and include activities such as textiles, pottery, music, and storytelling. The Service Manager and facilitator provide support with sensory impairment to ensure that people are able to socially interact, that the environment is right and that the activities are accessible. The initial assessment of patients is now carried out by Sense staff instead of VCSAs, which allows patient needs to be identified immediately and avoids duplication. Although the service is similar to other services that Sense provides, Social Prescribing activities are generally more three dimensional rather than two dimensional to meet the specific needs of the beneficiaries.

Patient case studies

Mrs A

Mrs A is 81 years old and lives alone, managing without a carer, in a warden assisted flat. She has a cleaner every Monday afternoon, who provides some company. Her eyesight is impaired and she rarely sees family or friends; she spends a lot of time alone. *'I do like company, but there's nobody to be company with...I do get lonely...because I can't see telly properly'*. Although a neighbour helps with her shopping, they don't socialise. She frequently has falls at home, which she doesn't report to her doctors; the last fall being three months ago. She found out about the Social Prescribing Service through her GP, *'I was very depressed for 18 months and I went off my food, I just wanted to lay in bed, I just wanted to pull the plug out....I just wanted to lay and die. I had no interest in anything'*.

The Voluntary and Community Sector Advisor (VCSA) told Mrs A about the various activities available through the Social Prescribing service, some of which she took up, with few expectations initially. Activities included arts and crafts at Sense, weekly exercise classes at The Titans and at Rotherham United. Transport was provided by Rotherham Community Transport. She also had a befriender, but decided not to continue with this service. She finds the activities at Sense enjoyable, and getting involved in Social Prescribing service activities has got her out of her depression, *'coming to these groups, I've got a social life and I feel better'*. Other members of the sense group have been helpful, for example, buying Mrs A fruit when her daughter hasn't been able to take her shopping.

Mrs B

Mrs B is 39, and lives at home with her son. Her mother and son are her main carers. She suffered a major stroke at the age of 31, leading to a loss of feeling down the right side of her body and mobility problems, a speech impediment, memory loss, and visual impairment. She also has asthma, severe anxiety and depression, which have led to a fear of going out and panic attacks. Occupational Therapists visit routinely and Rothercare provide support in relation to falls and she visits the Rotherham Intermediate Care (Council) once a week to improve confidence and balance. Mrs B sees her GP once a month and during the last six months she has been in hospital twice; the first time after having an asthma attack, and again when she had a fall and broke her wrist. Mrs B's GP told her about the Social Prescribing service and put her in contact with a VCSA, who did an initial assessment at home. The pilot nature of the scheme was explained to Mrs B, which she understood.

Since attending the first session at Sense, Mrs B has received advice and information about specific problems, as well as help finding practical solutions in relation to her disabilities, for example, opening tinned food. She pays £3.50 for increased sessional hours, including lunch. The group provides an opportunity to meet people and interact, and is seen as a lifeline, *'If it wasn't for the group, I might not be here now because I'd been that down and depressed...just getting out of the house has helped me with the fear, anxiety...talking to people lifts your mood and forget about problems at home'*. From taking tentative steps, she has become a proactive member of the group and has produced a Facebook account for the group to display their artwork. Her mother and son notice an improvement in mood during the week, but this dips at the weekend when there is less to do, and the session at Sense (on Wednesdays) seems some time away. Whilst Mrs B's many health problems will persist, attending sessions at Sense allows her to put her health problems aside for a couple of hours in a mutually supportive environment.

Mrs C

Mrs C is 63, and lives at home with her husband. They are both provided care every morning and night. She has had three strokes, and has chronic asthma and a blood disorder. The strokes have led to mobility problems, which cause her considerable frustration. Family members visit once a fortnight. She likes to read, and enjoyed driving but can't do this anymore. Many aspects of her life involve relying on others, for example, getting dressed, shopping etc. As a result, she sees no purpose to her life, *'your life is not your own'*.

Since her GP referred her to the Social Prescribing service, she has attended sessions at Sense for 15 weeks, using community transport. Initially, she found it intimidating and it took some time to adjust to the group because Mrs C finds it difficult to talk to new people, but over time she has become more confident, *'we talk about various things, about what we're doing, and how you're feeling'*. She didn't expect to get anything out of the service but has realised that she doesn't feel as isolated and was *'just looking at four walls without the service'*. Importantly, she noted, *'while you're here you don't think about your health conditions, you just get on with it'*. Any opportunities to attend more often would be taken up. She has socialised with another beneficiary outside of Sense sessions a couple of times and does reiki with another provider. At Sense there is something to look forward to each week, *'It makes us feel worthy instead of worthless, and less depressed'*.

Case Study 5: Tassibee

Organisation

Tassibee is a registered charity, established in 1993 to meet the educational, training and health and welfare needs of Pakistani women in Rotherham. Currently, the activities run by Tassibee include: a Carers' Project; a Ramadhan Project; a drop-in service; a prayer session every Friday; classes in Arabic, English, and positive parenting; events to raise awareness; an arts project; work with schools; and signposting families in crisis to support services.

Services provided through Social Prescribing

A one-to-one Peer Advocacy and enabling service for BME women is provided as part of the Social Prescribing service. The service is delivered in patients' homes, at other venues or the Tassibee Centre if required, and includes: one-to-one emotional/ practical support in the home and enabling patients to access community activities. Peer advocates provide support to enable access to health services and social care packages.

Patient case studies

Mrs A

Mrs A is 56 years old and lives at home with her daughter, daughter-in-law and two grandchildren. She is able enough to take care of herself, but has increasingly experienced joint pain from arthritis over the last two-three years. She was diagnosed with diabetes (over ten years ago), and she suffers from high blood pressure, high cholesterol, and has a visual impairment. Mrs A was referred to the Social Prescribing service by her GP.

Mrs A has social connections with local women and gets out of her home. She is involved in the rearing of her grandchildren, so rarely has time to feel alone during the day, but she feels very down at night when the arthritic pain is at its worst and during this time she begins to think about her other problems (not divulged). She cannot sleep at all. She struggles to speak English and is illiterate in her mother tongue. Her benefits were stopped two months ago and she accessed Tassibee for assistance. An advocate at Tassibee helped her fill in benefit forms and to apply for a free bus pass. She is pleased with the support she has received, *'I was completely stuck, I didn't know who to go to and what to do'*. She feels a little better within herself; the advocate checks on her through regular phone calls, and asks whether she wants to go out.

Mrs B & Mrs C

Mrs B is 77 years old and is in the middle stages of dementia, which she has had for approximately five years. As a result of her condition, Mrs B can be abusive and difficult. She also has arthritis and diabetes, but is still fairly mobile. Mrs B and her family were referred to the Social Prescribing by their GP, who referred them on to Tassibee. Mrs C is 43 years old and the daughter-in-law of Mrs B and her full-time carer. Although it is a large household (10 members of various ages), and they have managed, recently some family member's commitments have grown, and the burden of care has increasingly fallen on Mrs C, who does everything from bathing to changing her mother-in-law.

The family knew about Tassibee, but didn't know they were involved in delivering patient and carer support. The respite Tassibee provides allows the family to, *'plan forward, before we couldn't....It's given us a bit of social time as well'*. Mrs B is taken out once a week, according to her preference, and recently, her family has applied for direct payments to increase Mrs B's visits out to twice a week. She said, *'they (Tassibee) pick me up, drop me off, it's a very good facility'*. The burden on her daughter-in-law has been alleviated to some extent, *'some days you just need mentally to distance yourselves'*.

Mrs D

Mrs D is 72 years old and lives with her son and his family. The household consists of seven members, including Mrs D's husband who has various health problems. Her husband causes disturbance when he is in pain and this prevents Mrs D from having peace and getting sleep. She is severely depressed and feels alone; her family offer little reassurance and she doesn't have any friends. Her daughter-in-law is her carer, but she is often busy meeting her household's needs. Previously, Mrs D had a very busy, successful career, but had to give it up when her husband had a heart attack. She still enjoys reading, and writing poetry. Mrs D has arthritis, a visual impairment and various other health problems. She was referred to Tassibee by her GP, and as a result, the VAR Advisor did a home visit to discuss her needs.

A Tassibee Advocate takes her out once a week (for three hours); she has been shopping, to the bank, eating out, and for a walk in the park. *'Getting out has made me feel very good'*. She felt like she was locked in her home and the Social Prescribing service has supported her to get out. She went to an exercise class and Mrs D feels she benefited from it immensely, for example, her shoulder pain has gone and she has started walking with ease, noting *'a big difference'*. She has regained some independence, and feels better physically and emotionally because she has something to look forward to. Without the Social Prescribing service, she would withdraw within herself and become isolated again.

Appendix 2: Overview of funded social prescribing services in Rotherham



Service provider	Type of service or activity	Summary of service or activity
Active Independence	Peer advocacy with volunteering opportunities	Advocacy and support service for people who need help to access social care packages
Active Regen	Group activity/mobility sessions	(1) Strength and balance activities, (2) Computer gaming activities, (3) Walking for beginners, (4) Boccia
	Senior peer mentoring - 'Active Friends' buddy scheme	(1) Senior Peer Mentor training programmes, (2) Senior Fitness Testing sessions, (3) Moving More Often training course
Age UK	Advice and Information	Home visits providing welfare benefits advice
	Reablement service	Home based 1 to 1 practical and emotional support
	Befriending service	1 to 1 befriending service - in the home or community
Alzheimer's Society	Dementia Support Worker Service	Signposting, advice and support, including practical support to attend dementia cafes and other groups as appropriate
	Dementia Volunteer Befriending service	Volunteer led befriending service providing companionship and emotional support, and support to participate in leisure and social activities and other regular activities such as shopping

Service provider	Type of service or activity	Summary of service or activity
British Red Cross	Volunteer-led befriending and enabling service	Goal orientated volunteer befriending support to enable independence in the home and encourage community participation
Crossroads Care	Flexible carer respite service	Carer assessment; information and signposting; flexible respite; complementary therapies; carer training; peer support group
	Sitting service	Sitting service to enable carers to attend Caring With Confidence course
Elmet Archaeological Services	Drop-in reminiscence group	Facilitated reminiscence session: memory boxes, music, artefacts, and social interaction.
High Street Centre (Rawmarsh)	Activities Co-ordinator	Activities Co-ordinator introduces patients to activities in High Street Centre; volunteer befrienders accompany patients to activities of their choice; new activities will be set up in the Centre to meet patient needs
Kimberworth Park Community Partnership	Home visits and referral to community activities	SPS refers direct to KPCP Project Co-ordinator for home visit and referral to local neighbourhood services: community gym, gardening project, financial inclusion support, massage/pamper sessions, fitness groups, social groups, employment advice
Lost Chord	Music sessions for people with dementia	Professional musicians providing music sessions for people with dementia in Alzheimer's Society Memory Cafes
Montgomery Hall (Wath)	Activity Co-ordinator at Montgomery Hall	Activities Co-ordinator introduces patients to activities in Montgomery Hall and the wider community. New activities will be developed meet needs of patients. Volunteer befrienders provide transport
Rotherham Community Transport	Volunteer driver scheme and improved booking and scheduling service	Launch of volunteer driver training programme. Booking and scheduling will become responsive to individual needs. SPS referrals to RCT to be logged on a new system
Rotherham Ethnic Social Care Organisation	Two group activity programmes for BME carers	(1) Health & well-being sessions, (2) Cultural activities and away days.

Service provider	Type of service or activity	Summary of service or activity
Rotherham United Community Sports Trust	Home Exercise visits	Weekly home visits to help improve mobility/flexibility through gentle exercise.
	New York Stadium activity sessions	Weekly activity sessions including at the New York Stadium: gentle exercise, healthy eating advice, reminiscence/life stories, games, creative writing, lunch.
	Community based activity sessions	Similar sessions to those held at the New York Stadium but delivered in community venues in Wickersley and Dinnington
Royal Voluntary Service	Volunteer-led good neighbours befriending and enabling scheme	Befriending in the home, escorting to appointments, shopping on behalf of or with, linking people to community activities, transporting patients.
Satori Counselling	One-to-one therapeutic counselling and additional group work sessions	1 to 1 counselling at RAIN building or in patient's home if appropriate. Separate group sessions at Wickersley Library
Self Management UK	Caring with Confidence course	7-week Caring With Confidence course delivered in a community venue
Sense	Sensory art & craft group sessions	Sessions involve textiles, pottery, music, storytelling
South Yorkshire Centre for Inclusive Living	One to one Support Worker personal service	1 to1 Support Worker service to enable patients to live a more independent life: home visits and accompanying patients to appointments, shopping trips, social events and activities etc. Also help with benefits and accessing other statutory services
	Facilitated 'afternoon tea' sessions	'Afternoon tea' sessions in community venues facilitated by the Project Co-ordinator
Surehealth	Community based Tai Chi classes	Weekly Tai Chi classes
Tassibee	One to one Peer Advocacy and enabling service for BME women	1 to 1 emotional/practical support in the home and enabling patients to access community activities. Delivered by peer advocates with advocacy support to enable access to health services and social care packages.

Service provider	Type of service or activity	Summary of service or activity
Titans Community Foundation	Home visits from Rotherham Titans first team players	Four 2-hour weekly visits per patient - providing companionship and light exercise if required. Patients are encouraged to attend group sessions at Clifton Lane
	Group activities at Clifton Lane Sports Ground	Weekly group activities at Clifton Lane Sports Ground including light exercise, social activities
Unity Centre	Group activity sessions for Asian men	Group support for Asian men aged 50+ from BME communities, particularly Yemeni and Pakistani. Includes life stories/memories, exercise sessions, information sessions, end of project trip
Universal Embrace	Complimentary Therapy and social group sessions	Complementary therapy and social group sessions