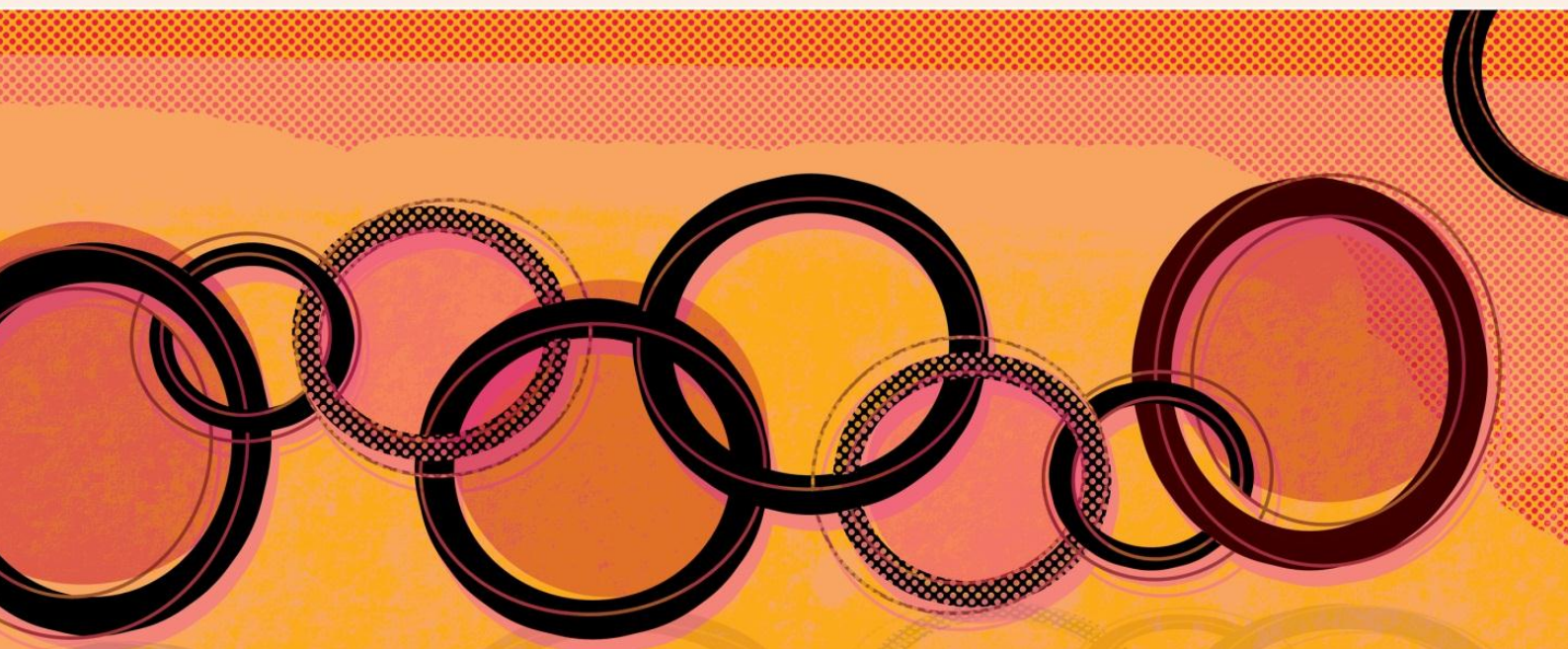


**The social and economic
impact of the Rotherham
Social Prescribing Pilot:
*Summary Evaluation Report***

September 2014



Rotherham Clinical Commissioning Group



The social and economic impact of the Rotherham Social Prescribing Pilot

Summary Evaluation Report

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Introduction

This report provides a summary of the findings from the independent evaluation of the innovative Rotherham Social Prescribing Pilot being undertaken by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University. It provides an assessment of the social and economic impact of the Pilot from the perspective of key stakeholders and follows an interim evaluation report, published in December 2013, which identified emerging lessons from the evaluation and provided a series of recommendations for stakeholders and commissioners going forward. A full more detailed report, including technical methodological information regarding the data and analysis undertaken, is also available.¹

1.1. What is 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. Social prescribing commissions services that will prevent worsening health for people with existing long-term conditions (LTCs) and reduce costly interventions in specialist care. It links 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 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.

1.2. An overview of 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 LTCs and their carers. 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.

The social prescribing model implemented in Rotherham was based around a core team consisting of a Project Manager and five Voluntary and Community Sector Advisors (VCSAs) employed by VAR, and a grant programme, which funded the development of new community-based services that filled gaps in provision, and enabled existing services to expand to meet additional demand:

¹ <http://www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham.pdf>

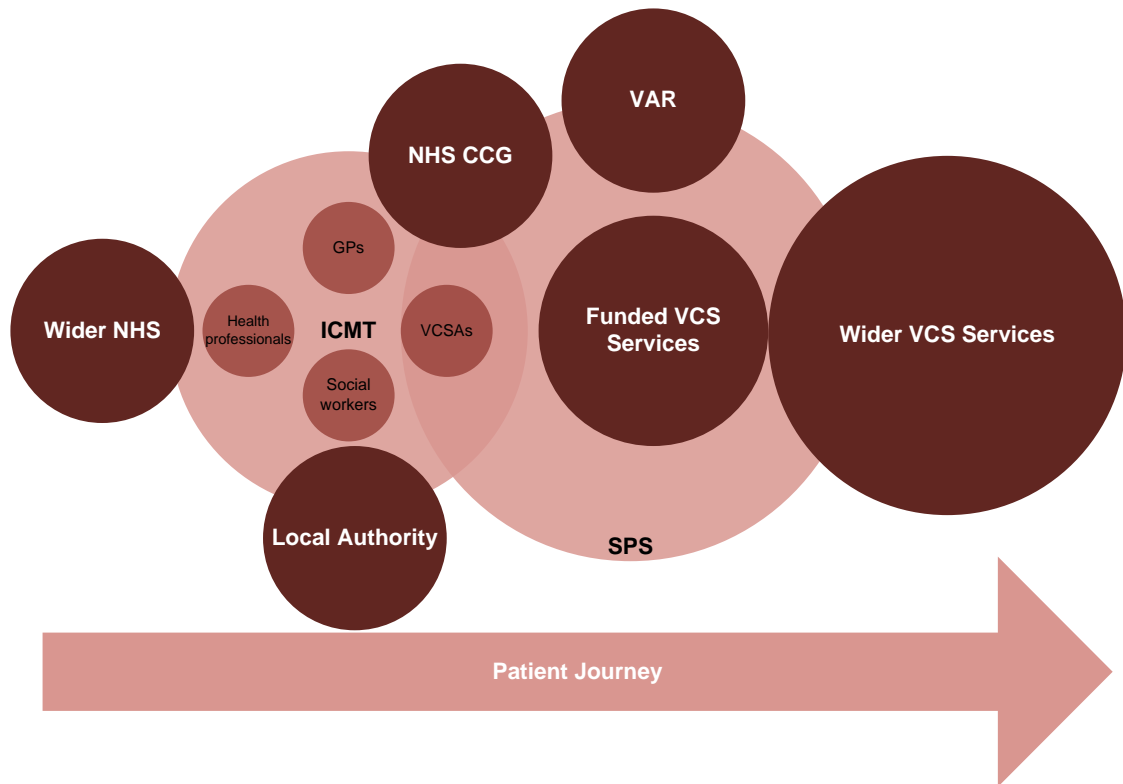
- the Project Manager oversaw the day-to-day running of the Pilot, including management of the grant programme, and acted as a liaison between VCS providers and wider NHS structures.
- VCSAs provided the link between the Pilot and multidisciplinary primary care teams. They received referrals from GP practices of eligible patients and carers and made an assessment of their support needs before referring them on to appropriate VCS services.
- through the grant programme **24 VCOs received grants** with a budgeted total value of just over £600,000. The grants enabled these organisations to deliver a **menu of 31 separate social prescribing services**. These services **acted as a gateway** for Social Prescribing Pilot patients to access the broader range of services available through the wider VCS.
- 29 (out of 36) GP Practices in Rotherham referred patients to Social Prescribing. Overall, **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**. In addition, many of the services provided aimed to serve as a **'first step'** for patients to access a wider range of community provision more independently in future.

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 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 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 stimulate debate about how general practice can be supported to improve outcomes and tackle inequalities.

Diagrammatic representation of the model is provided in Figure 1.

Figure 1: The Rotherham Social Prescribing Model



The social and economic impact of the Social Prescribing Pilot

2.1. Impact on the demand for hospital care

Using patient-level Hospital Episode Statistics (HES) provided by the Commissioning Support Unit (CSU), the evaluation mapped over time Social Prescribing patients' use of hospital resources, including unplanned care, focussing on two cohorts of patients in particular:

- those for whom **12 months of post-referral data** was available: 108 patients referred between September and December 2012
- those for whom **six months of post-referral data** was available: 451 patients referred between September 2012 and June 2013.

The number of **in-patient admissions, Accident and Emergency attendances and outpatient appointments** before and after referral was counted for both cohorts and change compared.

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**:

- **Inpatient admissions** reduced by 21 per cent within the 12 month cohort and by 14 per cent within the six month cohort. For patients who had been referred on to a funded VCS service the reductions were greater: 25 per cent within the 12 month cohort and 22 per cent within the six month cohort
- **Accident and Emergency attendances** reduced by 20 per cent within the 12 month cohort and by 12 per cent within the six month cohort. For patients who had been referred on to a funded VCS service the reductions were greater: 24 per cent within the 12 month cohort and 16 per cent within the six month cohort.
- **Outpatient appointments** reduced by 21 per cent within the 12 month cohort and by 15 per cent within the six month cohort. For patients who had been referred on to a funded VCS service the reductions were greater within the 12 month cohort (29 per cent) but less within the six month cohort (four per cent).

An overview of the analysis is provided in Table 1.

Table 1: Overview of change in per patient utilisation of hospital resources

	All patients referred to Social Prescribing				Patients referred to a grant funded VCS provider			
	Before referral	After referral	Change	% change	Before referral	After referral	Change	% change
12 month cohort:*								
No of in-patient admissions	1.46	1.17	-0.30	21	1.45	1.10	-0.36	25
No of A&E attendances	1.94	1.56	-0.39	20	2.19	1.67	-0.52	24
No of outpatient appointments	1.70	1.30	-0.36	21	1.90	1.36	-0.55	29
6 month cohort:**								
No of in-patient admissions	0.59	0.51	-0.08	14	0.58	0.44	-0.13	22
No of A&E attendances	0.76	0.67	-0.09	12	0.75	0.63	-0.12	16
No of outpatient appointments	0.74	0.63	-0.11	15	0.72	0.69	-0.03	4

* 108 patients

** 451 patients

Although these findings should be viewed positively, particularly in light of the consistent patterns identified, they should also be treated with some caution: there are currently too few patients in the sample analysed (in the case of the 12 month sample) and too little time has elapsed (in the case of the six month sample), to produce findings that are statistically significant. In addition, there is not currently a control group against which to compare Social Prescribing patients. Plans for future analysis include:

- analysis of additional patient cohorts: for example, patients who were referred towards the end of the Pilot, and patients referred to different types of services
- analysis of a longer time series: of up to two years pre- and post-referral to Social Prescribing
- development of a robust control group, through administrative data sources and statistical matching procedures
- access to data on use of social care and residential care by Social Prescribing patients and carers, in order to assess a wider series of impacts.

2.2. Social impact

The social impact (i.e. outcomes for patients) of the Social Prescribing Pilot was explored through analysis data collected by VCSAs using a well-being outcome tool, and case studies with five service providers, including qualitative interviews with beneficiaries and their carers (17 interviews in total).

Well-being

The well-being outcome tool measured patients' well-being and their progress towards self-management of their condition through eight measures using a five point scale. Analysis focussed on 280 patients whose well-being measures had been followed-up after 3-4 months: **83 per cent of these patients had experienced positive change** in at least one outcome area. When the results were broken down by category it showed that progress was made against each outcome measure and 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.

An overview of the analysis is provided in Table 2.

Table 2: Overview of well-being outcome measure baseline and distance travelled data

Outcome area	Baseline			Distance travelled			
	Count	Mean	Low scores* (%)	Count	Mean	Progress made	
						All (%)	Low scores (%)
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 two or less

The distance travelled by Social Prescribing patients across a range of outcomes after three-four months demonstrates the potential of social interventions to address some of the key psycho-social determinants of health. Importantly, the greatest progress was made against the lowest scoring outcome areas (work, volunteering etc., and feeling positive); and a majority of low scoring patients made progress. This 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.

Case studies

The case study interviews provided specific examples of the social impact and outcomes of Social Prescribing services for beneficiaries and their carers. These outcomes can be grouped in four broad themes of increased well-being, reduced social isolation and loneliness, increased independence, and access to wider welfare benefits:

- **Improved well-being:** the case studies revealed numerous examples of improvements in patients' and carers' general sense of well-being, but also specifically in the area of mental well-being, particularly associated with anxiety and depression and personal confidence and self-efficacy.

"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."

- **Reduced social isolation and loneliness:** case study interviews highlighted the importance of linking people with limited mobility and social contact with the wider community, either through accessing community activities (for the more mobile) or through befriending and other services provided in patients' homes.

"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."

- **Increased independence:** a number of interviewees whose mobility was limited were able to become more independent as a result of improvements in their physical health. There have also been examples of beneficiaries becoming involved in independent social and community action since accessing services.

"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."

- **Access to wider welfare benefits:** a number of case study participants highlighted the importance of advocacy services in improving their (and their carers) awareness of various benefits that could be available to them and supporting them to make applications for benefits such as Direct Payments. This was seen as an important step in the realisation of other outcomes, such as improved well-being and independence.

2.3. Economic and social cost-benefits

The evaluation also involved an analysis of the economic and social benefits of the Social Prescribing Pilot: economic benefits were estimated based on the reductions in use of hospital care; social benefits were estimated based on the well-being outcome data and a survey of Social Prescribing funding recipients.

Economic Benefits

A number of positive benefits (cost reductions) to commissioners linked to the Social Prescribing Pilot have been estimated on the basis that the benefits identified lasted at least one year:

- **estimated total cost reductions by the end of the Pilot:**
 - £552,000
 - a return on investment of 50 pence for each pound (£1) invested
- **total cost reductions for patients referred to funded VCS services by the end of the Pilot:**
 - £423,000
 - a return on investment of 38 pence for each pound (£1) invested
- **potential cost reductions of £415,000 in the first year post-referral** when the service is running at full capacity²
- based on these cost reductions, if the benefits identified are fully sustained over a longer period, **the costs of delivering the service for a year would be recouped after 18 to 24 months**
- **the longer-term cost reductions for commissioners for each full year of service delivery could be much higher:**
 - 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 for each pound (£1) 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 for each pound (£1) 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 for each pound (£1) invested.

It is important to emphasise that at this stage these figures are estimates based on 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.

Social Benefits

A number of social benefits associated with Social Prescribing were estimated:

- the well-being benefits for Social Prescribing patients
- the volunteering undertaken in the delivery of funded Social Prescribing services
- the additional welfare benefits claimed by patients referred to funded Social Prescribing services
- additional funding accessed by funded VCS services providers that could be attributed to their involvement in the Pilot.

Financial proxies were used to provide a monetised assessment of these benefits based on the methodological techniques associated with social return on investment (SROI) analysis.³ The findings show the following:

² This is based on the estimated savings for the second year of the Pilot i.e. the first full year of delivery

- **the estimated value of well-being benefits:**
 - between £819,000 and £920,000 by the end of the pilot
 - potential well-being value of between £660,000 and £742,000 in the first year post-referral when the service is running at full capacity⁴
 - the potential for positive social return on investment during the first year following referral to Social Prescribing
- **the estimated value of volunteering:**
 - £81,000 based on the national minimum wage
 - £148,000 based on the national median wage
 - 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:**
 - funded VCS services support Prescribing 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, Employment Support Allowance
- **the estimated value of additional funding accessed by funded VCS service providers:**
 - three funded VCS service providers 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 programme).
 - 11 funded VCS service providers reported that Social Prescribing Patients had accessed additional services though 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.

³ Details of the valuation techniques applied are provided in the Full Evaluation Report

⁴ This is based on the estimated well-being value for the second year of the Pilot i.e. the first full year of delivery

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 concluding chapter draws together findings from both reports to provide an overall assessment of the Pilot and highlight some implications for future service delivery and commissioning.

3.1. 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. 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 would not otherwise have been aware of or able to access.

3.2. Outcomes for the public sector

Patients accessing the Pilot were already frequent users of hospital care and assessed as at high risk of requiring unplanned hospital care in the future. As such, the effectiveness of Social Prescribing at reducing patients' use of hospital care was an important measure of success for local NHS commissioners. So far the evaluation evidence is very positive. Social Prescribing patients' use of hospital resources reduced by up to a fifth in the 12 months following their referral to Social Prescribing. This translates into potential positive financial returns to commissioners within two years following the initial referral. At this stage these findings carry an important caveat: there are too few patients in the sample analysed and too little time has elapsed to produce findings that are statistically significant.

In addition to these direct health related benefits, the public sector has experienced broader outcomes as a result of the Social Prescribing Pilot. For example, patients accessing the service were generally more satisfied with the support they received and felt better supported to manage their condition. There is also emerging evidence that non-health services, in particular social and residential care, benefit from similar reductions in resource utilisation and service delivery costs.

3.3. Outcomes for the local voluntary and community sector

The local voluntary and community sector (VCS) has also benefitted from the Pilot. The £0.6 million that was invested in VCS Social Prescribing services was 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 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 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.

3.4. 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 2012 statutory bodies are required to consider social value at all stages of the commissioning and procurement process. 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 cost of public services, improvements in the health and well-being of local people, independent community engagement and social action, wider economic benefits in the form of welfare entitlements and funding, and a more sustainable, vibrant and innovative local VCS. It shows that social value is accrued by a range of different stakeholders and not just commissioners and beneficiaries. Local statutory bodies should therefore be encouraged to consider the social value that could accrue to 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 VAR has come through very clearly throughout the evaluation. 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.

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