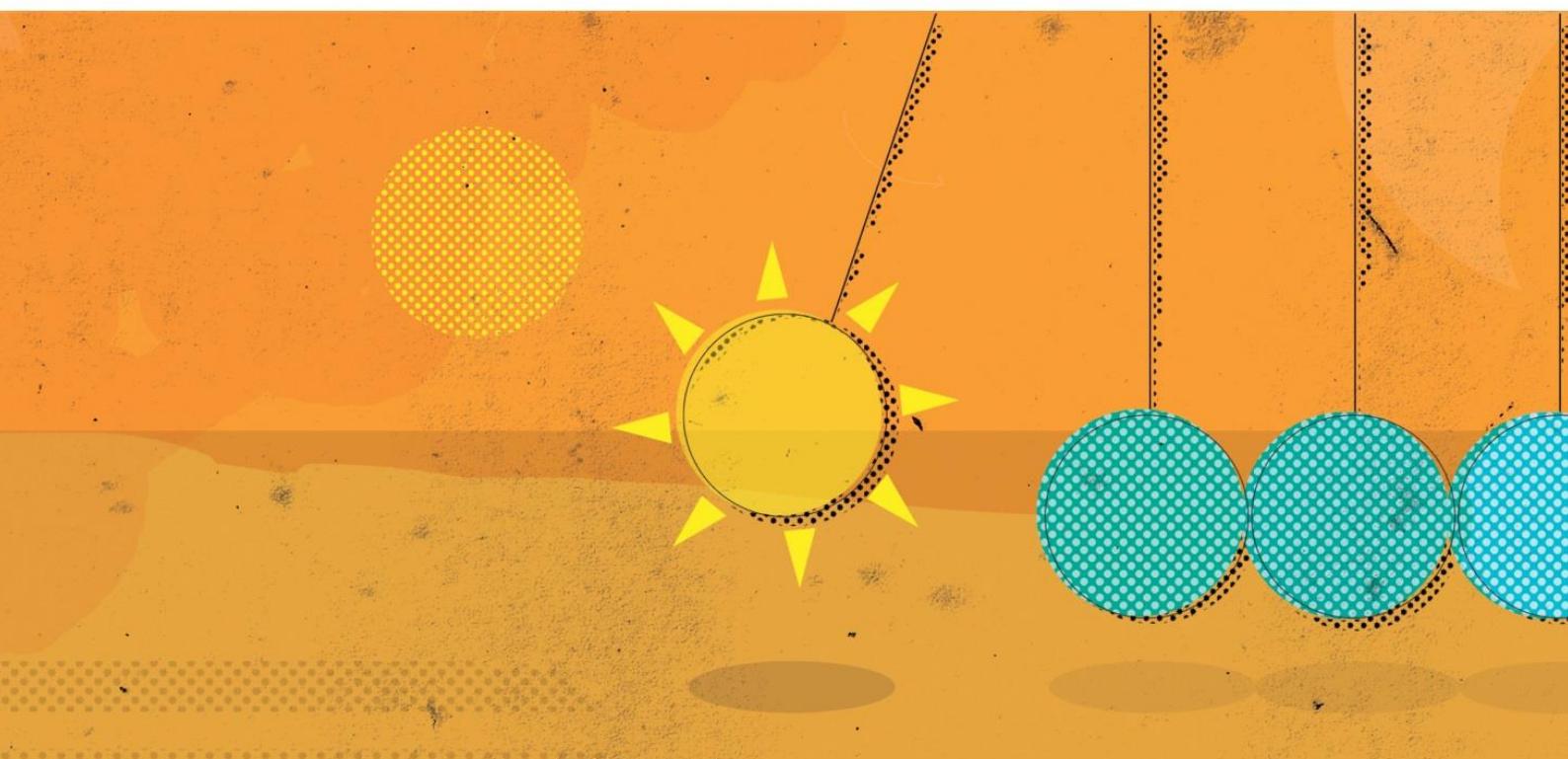


Evaluation of the Rotherham Mental Health Social Prescribing Pilot

November 2016



Rotherham Clinical Commissioning Group



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Introduction

This report provides the findings of an independent evaluation of the Rotherham Social Prescribing Mental Health Pilot undertaken by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University. The Pilot ran from April 2015 to March 2016 and was delivered in partnership by Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH) and a group of local voluntary sector organisations led by Voluntary Action Rotherham on behalf of NHS Rotherham Clinical Commissioning Group (CCG). It is intended to help users of secondary mental health services build and direct their own packages of support, by accessing tailored voluntary activity in the community, with a view to achieving sustainable discharges from mental health services.

1.1. Evaluation Aims

The Evaluation was commissioned with the following aims:

- to understand the impact of the Pilot on the well-being of service users
- to identify wider outcomes and social benefits associated with the Pilot
- to understand the impact of the Pilot on discharge from secondary mental health services
- to explore the potential economic benefits of the Pilot
- to capture stakeholder perspectives on the effectiveness the Service and identify key learning to inform future delivery and commissioning.

1.2. Methodology

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

- Five interviews with key stakeholders during the early phases of the Service. The interviews explored the aims of the Pilot, and the key successes and challenges of the early stages of service delivery.
- Three case studies of activities funded through the Pilot, which included five interviews with staff and volunteers involved with delivering the activities, and interviews with six beneficiaries of the Pilot, focussing on their experiences of engaging with the Pilot, including the kind of activities they were accessing, and the difference this was making to them both practically and emotionally.
- Well-being outcome questionnaires completed by 59 service users at two points in time: upon first engaging with the Service (baseline) and after approximately 3-4 months (follow-up) as part of a review.

- Monitoring data from VAR on the number of people referred to the Pilot, take-up of services, discharge rates from secondary mental health services and a series of wider outcome measures.

1.3. Report Structure

The remainder of this report is structured as follows:

- Chapter 2 provides an overview of the Rotherham Social Prescribing Mental Health Pilot
- Chapter 3 discusses the emerging lessons from the Pilot
- Chapter 4 provides analysis of the outcomes and impact of the Pilot
- Chapter 5 is the conclusion and provides a summary of the main findings.

2

An Overview of the Rotherham Social Prescribing Mental Health Pilot

This chapter provides an overview of the Rotherham Social Prescribing Mental Health Pilot. It discusses the background to the pilot, the service pathway developed, and the types of social prescribing services provided through the pilot.

2.1. Background to the Pilot

The Rotherham Social Prescribing Mental Health Pilot was developed to help people with mental health conditions overcome the barriers which prevent discharge from secondary mental health care services. It initially ran from April 2015 to March 2016 but has since been extended to March 2017. The service helps service users build and direct their own packages of support, tailored to their specific needs, by encouraging them to access personalised services in the community provided by established local voluntary and community organisations, and to develop their own peer-led activities.

The Pilot was funded by NHS Rotherham Clinical Commissioning Group (CCG) and delivered in partnership between Rotherham, Doncaster and South Humber Foundation Trust¹ (RDASH) and a consortium of 17 local voluntary sector organisations led by Voluntary Action Rotherham. It builds on and is integrated with the successful Rotherham Social Prescribing Service for people with long term health conditions which has been operating since 2012.

The pilot was established with three key aims:

1. Creating opportunities for mental health service users to sustain their health and well-being outside secondary mental health services
2. Creating more capacity within secondary mental health services
3. Creating efficiencies within mental health services.

¹ RDASH has historically provided mental health and learning disability services across South Yorkshire and North East Lincolnshire, but recently expanded its remit to include community services such as district nursing and health visitors.

The initial period of the pilot focussed on two service user clusters:²

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

More recently, the service has begun receiving referrals of Cluster 4 with a view to preventing them becoming longer-term patients (i.e. preventing them reaching Cluster 7).

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

There are also a number of national and local contextual and strategic policy drivers that provided a strong rationale for establishing the pilot and continue to influence its development. Nationally, since 2011 the NHS has prioritised improvement in the outcomes, physical health and experience of care of people with mental health problems, and a reduction in avoidable harm and stigma.³ But despite this renewed focus there has been an increase in people using mental health services in recent years, leading to inadequate provision and worsening outcomes, including a rise in the number of people taking their own lives.⁴ In response, in February 2016 the Mental Health Taskforce to the NHS in England, in their 'Five Year Forward View for Mental Health'⁵ recommended a series of priority actions for the NHS by 2020-21. These included expanding proven community-based services for people of all ages with severe mental health problems who need support to live safely as close to home as possible and a commitment to promoting good mental health and preventing poor mental health.

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

³ HM Government (2011). *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*

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

⁵ Ibid

Locally, the RDASH transformation plan⁶ recognises that services are currently provided on the basis of what services are available, often channelling service users through particular cluster based pathways, rather than the needs and circumstances of the person seeking help. As a result patients are being brought into secondary services when more appropriate alternatives exist and many are staying in service for long periods of time, becoming dependent. This has led to services becoming log jammed meaning new people in need are not getting help in a timely way and long term service users are not being supported to live the best life they can. RDASH recognise that local mental health services as they are currently configured are neither efficient nor effective and have identified the need for an ambitious step-change in service provision in which patients are encouraged and supported to live more independent lives and receive the care they need according to their individual circumstances, delivered closer to home where possible.

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

2.2. The Social Prescribing mental health pathway

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

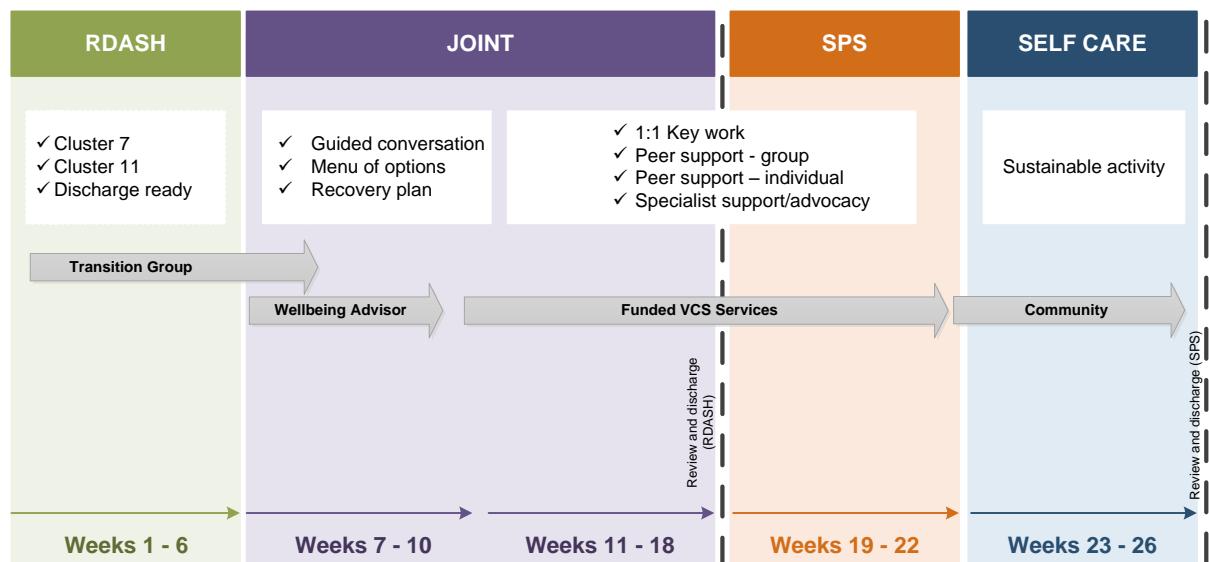
- **Week 1-6:** During the early stages of the pilot, referrals could either be made on an individual basis by an RDASH practitioner or through a transition group that was established to provide additional support to help some of the longer term users of mental health services prepare for discharge. The group ran for an initial 6 weeks before patients met with the Advisors in weeks 7-8. For individual referrals, the pathway starts as per week 7 below.
- **Week 7-10:** A period of joint working between social prescribing and RDASH. During this period VAR will liaise with SPC if there are any problems. During this period the service user case remains an open RDASH case and any concerns and observations are discussed with Social Prescribing Clinician (SPC) and transition delayed if appropriate.
- **Week 11- 18:** A joint review meeting between the social prescribing advisor, RDASH SCP and the service user, is held to assess progress with social prescribing. If the service user is progressing well with social prescribing RDASH will withdraw at week 18. If concerns are identified and it is felt that social prescribing engagement cannot be sustained, the service user will remain in the care of RDASH and continue with social prescribing with increased support, or they will return to care of RDASH and withdraw from social prescribing.

⁶ RDASH (2016). *Recommendations for Transforming Rotherham Adult (18+) Mental Health Services*

- **Week 19-26:** During this period the service user's primary contact is the social prescribing advisor or one of the voluntary sector organisations providing support through the programme. If there are concerns the SCP is available to provide advice. If re-referral is necessary the RDASH triage worker assesses the emerging risk and initiates a rapid re-access in to RDASH services.

An overview of this pathway is provided in figure 2.1.

Figure 2.1: The Rotherham Social Prescribing Mental Health Pilot pathway



2.3. Social prescribing services

16 different types of voluntary and community sector services were developed and received funding through the pilot. A combination of individual and group based services was provided in the areas of:

- **Befriending plus**, providing peer support for people lacking confidence to engage in community activities independently (four providers).
- **Community engagement groups**, providing opportunities for people to engage social activities base around a particular hobby or interest (five providers).
- **A community hub** (in Wath), where people were supported to engage in existing social activity in their community, with a view to enabling them to engage independently in the longer term.
- **Education and training** opportunities, enabling people to build practical skills and confidence in areas of interest including working towards employment.
- **Therapeutic services**, enabling people to develop relaxation and mindfulness techniques in a supportive environment.

An overview of the individual services provided is presented in table 2.1.

Table 2.1: Overview of services funded through the Rotherham Social Prescribing Mental Health Pilot

Organisation	Individual or group service	Service Description
Befriending Plus		
British Red Cross	Individual	One to one home enabling service to link patients into community activities. Additional options: massage, equipment loan service, and transport to medical appointments.
Rotherham Rise	Individual and Group	One to one befriending and enabling support for women. Additional options: counselling, peer support and group activities.
Rotherham United Community Sports Trust	Individual and Group	One to one home befriending and enabling. Additional options: healthy lifestyle group, walking group and match day experiences.
YAWR Services	Individual	One to one home befriending and enabling service. Enabling service to link patients into community activities.
Community Engagement Group		
ABC Forum	Group	Therapeutic art group. Flexible sessions to support people who would like to engage in art in a social environment.
Active Regen	Group	28 week sport and physical and social activity group sessions.
Casting Innovations	Group	'Men in sheds': model making, crafts and social group. Flexible to respond to suggestions from participants.
Ministry of Food	Group	8 week practical cookery courses.
Places For People Leisure	Individual and Group	3 hours' one to one support from a fitness trainer and then 13 group gym sessions or swimming with parallel group sessions.
Community Hub		
Montgomery Hall, Wath	Individual	Ongoing practical and confidence support to attend community and social activities independently in the longer term.
Education and Training		
Elmet Archaeological Services	Group	12 week structured learning programme including personal development classes and archaeology and history.
The Learning Community	Individual	12 hours one to one support in ICT, using online services, functional skills in maths and English, confidence building and personal development Including employment skills.
Workers Educational Association	Group	6 hour taster courses in: yoga and relaxation, 'Looking Good Feeling Great', confidence and self-esteem building, 'Creative Crafts', and artisan chocolate making

Therapeutic Services

Mindful Tai-Chi	Group	12 bespoke Tai Chi group sessions geared towards mental health patients as a pathway towards community based tai chi classes.
Rotherham and Barnsley Mind	Group	Therapeutic art group for people who would like to engage in art in a social environment.
Radiance & Relaxation	Group	Group yoga and laughter therapy sessions.

2.4. Key outputs to date

By the end of March 2016 **156 mental health service users had been referred to the pilot**, of whom 141 (90 per cent) had engaged in an initial meeting between representatives of the service and RDASH, and **136 (87 per cent) had taken-up a service** on an individual or group basis. This suggests that during the first year of the pilot a large majority of the service users identified by RDASH for social prescribing have been appropriate and well prepared for the transition from 'traditional' mainstream services.

3

Emerging lessons from the pilot

An objective of the evaluation of the Social Prescribing Mental Health Pilot has been to identify overarching lessons, about the nature of the services and the social prescribing model employed, that can inform the development of the service going forward. A range of perspectives were gathered through qualitative interviews with stakeholders such as commissioners, staff coordinating and delivering mental health services, VAR advisors, staff and volunteers delivering social prescribing activities, and patients referred in to the service. This chapter provides an overview of these lessons. It is divided into two sections: learning from service delivery and learning about the social prescribing model and processes.

3.1. Learning from service delivery

Through interviews conducted with people running and volunteering within provider organisations, as well as with patients who had been referred into the service, a number of lessons were identified about several aspects of running activities as part of the pilot.

Adaptability and the person centred nature of social prescribing activities

All three case studies commented on the need for their plans to be adaptable in order to meet the needs of the patients being referred. Each set-out with a plan for the group, which planned various topic/activities to be covered, but very quickly realised that these wouldn't necessarily form the basis of the sessions. Each case study talked about responding to the needs of the individuals attending on a week by week basis, to ensure that patients got what they needed from the sessions. Although provider organisations still talked about the importance of planning the sessions, the ability to work 'off plan' is an important lesson which should inform future service delivery organisations.

"I had a sort of a plan in my head how it was going to progress, it didn't go that way. It went at a different pace and it went in a totally different tangent, but it worked. Previously what we've done when we've done a course or a series of workshops... I've had an idea of sort of a lesson plan, a scheme of work...it didn't go that way in that we found that because the groups are very very mixed ages, abilities, past experience, we just went with the flow. It went at its own pace, and it took its own direction... So we had a plan, it didn't go to plan, but I think it worked better" (Social Prescribing service provider)

A volunteer within another service reflected on the need to be reflective and ultimately adaptable:

"With the kind of groups that you're going to get on this kind of service, because they are more disparate individuals with very different expectations, very different experiences of this kind of stuff, and I think planning that would be a nightmare, you know, and hats off, that they've managed to deliver a kind of semi structured way of doing it rather than it being, you know, we're going to do this on week one, this on week two, it probably wouldn't have worked... And I think that kind of fluidity has been essential, and for us really appreciated" (Volunteer and service user)

Relaxed environment

As well as the flexibility of the sessions, each case study organisation reflected on the importance of having a friendly, relaxed environment. People felt that this led to them feeling encouraged to contribute their ideas and suggestions for the sessions. The lack of rigid rules within activities also enabled people attending sessions to feel relaxed and able to join in with sessions at their own pace. One interviewee referred to this in terms of being able to 'grow within the service' and having the 'freedom to be ourselves'.

Patients interviewed agreed that the outcome would have been very different for them if they had to sit and follow a set structure in a formal context. It was clear that patients felt that services had worked because they were well planned but ultimately flexible.

"Well, it isn't a classroom, and you know we're going back to that 'planned sessions', I've got a broad plan of what I'd like to do each week, but it doesn't always happen. We go off and we'll end up talking about somebody's experience when they lived in Africa, and we'll just sit. It's a nice relaxed atmosphere. It's definitely not... I don't like having that mantle of teacher/lecturer, because a lot of these people have a lot more experience than me" (Social Prescribing service provider)

People also referred to the 'caring' nature of the organisations, saying they felt as though those running/attending the sessions were supporting them and 'looking out for them'.

Supporting people to access the services

Another important lesson was the importance of supporting patients to access the activities, particularly for the first visit. Case study organisations reflected on the challenges associated with encouraging people to come for their first visit:

"We had a lot of problems actually getting service users in the door. That initial contact is and can be hugely time-consuming... we make contact with them, sometimes it's through befrienders, sometimes it's through a family member, sometimes they can't or choose not to answer the phone, sometimes we need to organise door to door transport for them, so the management of individuals is difficult. It's nearly always getting them to the first session...what we've found is once that happens, they're fine." (Social Prescribing service provider)

A member of staff from another case study reflected on the same challenge:

"I've got a list of people who have been referred, who I've had telephone conversations with, email exchanges with, who never actually arrive, because there's something that gets in the way" (Social Prescribing service provider)

Service users talked about their anxiety about attending a session for the first time, including fears which ranged from leaving the house, how to get somewhere new, meeting new people and trying a new activity.

"It took me about 15 minutes to get from the car park to this door. Well it took me about 10 minutes to get up the stairs, it took me another 5 minutes to get through this door, because a closed door, I don't know what's on the other side." (service user)

One interviewee also referred to the fine line between being encouraged and feeling under pressure to accept a referral, highlighting how the service had got that balance just right.

"People like us either need to be forced to do something, or will go, 'no you're forcing me so I'm not doing it', so it's a very, very difficult line...I think VAR are really good, and in my case the lady I dealt with was superb and, you know, had to play to my foibles to get me here, and she did, she did a really good job, and you know, she deserves a medal" (Service user and volunteer)

There was a range of ways in which the case study organisations' staff and volunteers were trying to encourage attendance, and all agreed that the majority of service users that attended the first session went on to become regular attenders. Staff from all three case study organisations discussed the time between receiving a referral and actually meeting the patient at the first session as being critical, and involving multiple telephone messages and conversations, and sometimes visits.

Staff recognised the importance of Voluntary Action Rotherham (VAR) within this process, and service users did refer to the excellent levels of support VAR advisers provided. However, there still appears to be a need to explore how additional support can be provided in some cases.

Through a discussion between staff and volunteers at one of the case study organisations, the idea of providing a short video providing images of the service, was proposed as one way of reducing anxiety:

"A short bit of video of the place, and you know, within a group perhaps if everybody consents, so that when they go in to meet somebody, they can bring up a little short couple of minute video, even with pictures of the outside of the building, the way in, what [staff] look like...because when you're depressed it's very difficult to make that step between leaving your house, to more you know about where you're going, the easier it gets" (Volunteer and service user)

A member of staff from one case study highlighted the amount of work that sometimes goes into enabling a patient to attend the first session. This member of staff sometimes makes multiple calls, and has even gone out to meet the patient in order to support them to attend. Although the SLA between VAR and individual services does allow payment for delivery hours not relating to direct work with patients it appears some providers may be under-reporting this time so not to detract from time spent directly supporting patients.

Another suggestion from a volunteer was that it might be useful to provide a newly referred patient with a 'buddy', which would be someone who had progressed from

patient to volunteer, who could make contact, and either go and meet the newly referred patient, or at least arrange to meet them outside the building and they could walk in together to reduce anxiety.

"It's that initial getting out of the house, and getting to a group. And the fact that you're going into an environment where you know nobody...It's like, if there was somebody for instance who would really want to come to the group, but is struggling because they don't know anybody, I would think it's a good suggestion for social prescribing to say is there anybody in the group, such as me, that'd be willing to go along to the person's house, with somebody from social prescribing, and meet them" (volunteer and service user).

Staff and volunteers within the case studies valued the opportunity provided by VAR to meet with other service providers, as these gatherings enabled people to make new contacts, and discuss ideas for their services. In particular, one service valued the way in which VAR encouraged different services to do short presentations outlining their activities and the impact they were having. Developing a better understanding of other services available was also discussed in terms of making referrals between services. On this point, one volunteer suggested that more could be done to make links between services. It was also suggested that it was important for VAR to have as much information as possible about each service, so that they fully understand what is being offered, and so they can in turn provide service users with detailed information.

One member of staff from mental health services reflected on the importance of the person who supports service users to access their first services. She suggested that she felt it was a more successful process when they are supported to attend their first session by a familiar member of staff, but said it would be interesting to look into this further.

Social Prescribing as 'a break' from normal therapies

Volunteers within one service reflected back to their time as service users who had been referred into the Social Prescribing service, and suggested that they had found the activities a useful break from the normal therapies they accessed through mental health services. They suggested that coming to a group activity enabled them to have valuable social interactions, and they felt that they made great progress via attending. They reflected that they had been in various therapies for some time, and they felt that the progress they made whilst attending the social prescribing activity, both as patients referred but also latterly as volunteers, had enabled them to make important personal progress.

This view is supported by staff within RDASH, who have suggested to VAR that social prescribing would work well both as a *progression from* and *running alongside* existing traditional therapies, so patients have the opportunity to practice techniques and skills they have learnt which would make the therapy more effective.

3.2. Learning about the social prescribing model and processes

Time to establish the service

Commissioning staff, staff involved within mental health services and advisors at Voluntary Action Rotherham all referred to the time it had taken to establish the service, and start to see referrals coming through the system:

"It was slow to get started. It was slow to get the staff working in RDASH to let go of their patients, it was slow at first to get the people to want to be involved in

Social Prescribing and be involved with the voluntary sector. As people did get involved and actually could see what the outcomes were for their colleagues and friends who were going through the system, then it's become a lot easier... now the nursing staff can see the effect it's having on people, and the people themselves, it's getting easier to actually get people engaged" (Commissioner)

Although this time lag was not unexpected, in that other social prescribing services had experienced similar issues in the early stages, some staff identified that the process of ensuring service users within mental health services were ready to be referred did mean that the numbers of referrals were slow at first. As one member of staff explained:

"It's quite a significant event in their lives if they've been supported by services for several years...we found that we weren't able to put people through the project so easily in the early months because it was taking us a lot longer to, it's probably taking us the first year of the pilot to start to explain it to people and for them to start to feel ready that they can do something different" (RDaSH staff)

When people felt more confident about the service, and the referral process, then the referral rate increased:

"The referral rate was very, very slow, and we were really, really worried, because we'd kind of arbitrarily picked-out a number of referrals that we hoped to achieve. And then as we got into it, it was quite clear that we weren't going to achieve that because of these issues, and it was probably unrealistic with something completely new that needed to be embedded, that we would get a rapid referral rate straight away. However, the last quarter, there's just been a massive upsurge in referrals, so we were aiming at sort of 20 a month, and I think in the last months of the quarter we were there or above that." (RDaSH staff)

Developing confidence in the Social Prescribing model was an issue for service users but also for staff working in mental health services. When this was explored through interviews, it was suggested that relationships between staff and service users were in some cases quite long term, and staff felt a high degree of responsibility for service users. It also took time for staff to understand the social prescribing service, and crucially how this differed from what mental health services offered already.

There was some nervousness about introducing a change into the service, and in some cases concern about how service users would fare within external services. Staff within mental health services reflected on the need for constant dialogue with staff in order to support the transition and manage relationships.

However, on reflection staff interviewed stated that the pilot had enabled them to build relationships with VAR advisors and voluntary organisations, and that they could see the benefits for service users that had been referred. Staff were therefore growing in confidence, and starting to explore how they could refer people at an earlier stage. One staff member talked about having a lot of faith in the service, as "*a way of working that actually quite radically changes people's lives*" (RDash staff) and the potential it has to keep supporting people in the future. Some interviewees referred to this as the start of a culture shift within mental health services.

"I think on reflection we did everything really quickly, and I suppose I didn't realise what a significant undertaking it was going to be, not in terms of work, but in terms of facilitating quite a strong cultural shift. Because it was so new, and it was such a new opportunity and one that we'd never had before. And I

think I assumed that everybody would be as delighted as I was...but certainly it's grown in momentum" (RDaSH staff)

Sustaining service user involvement in social and community activity

Services had found a variety of ways of enabling the service users to sustain involvement in the activities at the end of the referral period. This can be seen as a point of strength of the model, as well as a point of strength of the individual services and people involved. It demonstrates that the pilot has been effective in achieving one of its key goals of sustaining service users' involvement beyond their prescription by providing *pathways to and support for independent social and community activity and action*.

However, a number of interviewees wanted to highlight challenges with the referral timeframe, particularly, they suggested, for patients involved in mental health services. The key issue that was that, at the end of the referral period, people may feel heightened anxiety about not being able to continue with an activity which they have come to rely on, or has come to be part of their weekly routine.

"At the time I was concerned with what impact it was going to have to then suddenly have to stop that" (Service user)

And:

"People come to depend on these sessions, for a lot of us it's the only time we go out of the house. And if you imagine, for the first 4 weeks you're just getting to know people, you're not unwinding as much. And by the time, especially with this...just as you're learning, just as you're getting on your feet to be able to do things, it's like, 'no, the money bank stops rattling'. (Service user)

And:

"Also there is this point that with social prescribing, it's again it's a regimented period of weeks...it's what happens, it still worries me for a great deal for a lot of people..." (Volunteer)

When discussing this issue with services and service users they highlighted the importance of support to enable organisations to enable transitions for service users at the end of the referral period:

"It would be nice to see more funding for it, obviously... you can't provide a service for free... but also the awareness that that [remaining involved] an option... if you finish your ten weeks or whatever, what do you do at that point? Do you go back to your doctor and say, 'I was feeling OK, but now I'm not anymore because I'm not going to my group', or do you go back to therapy, or do you go back to VAR" (Service user)

In each of the three cases explored for this evaluation solutions have been found to enable people to continue their involvement. This highlights the importance of the additional capacity building support provided by VAR to these types of small groups and it will be important to explore over time the extent to which individual's involvement, and the services and groups that have been developed, are sustained.

The point at which a referral is made

A number of service users referred to the point at which they were referred into the social prescribing service. Within these reflections, people suggested that they had been frustrated that they had not been able to access the service earlier, as they feel

that the benefits they experienced from attending social prescribing activities would have helped them.

"Going back to the VAR thing, I think they should be brought in earlier on in the process. My understanding is that you have to go through the hoops of having your therapy first, before you get offered VAR, and if I'd gone straight to VAR, there would never have been any need for therapy...why can't they, because they do a thing called access group or something first, or the access team, that decide what sort of thing...why they couldn't go, 'why don't we just go straight to VAR, or alongside [another therapy]" (Service user)

Of course, Social Prescribing didn't exist previously so there weren't the mechanisms to refer people for support earlier in the mental health services pathway. However, this comment does highlight the preventative potential of social prescribing and the possible benefits of a wider roll out of social prescribing within secondary and primary mental health care services.

Within these reflections, people suggested that they had felt that the social prescribing activity had enabled them to make very good progress in terms of well-being as well as confidence. One service user suggested that social prescribing could also be used during a break from other therapies:

"If you can imagine, if you're given a 16 week therapy thing, after say 10 weeks, you then went out and did something like this, went into a group, went out and did something, but then you go back into your therapy... I'd be very interested to know what the kinds of results were that the therapist would then get. Because to me that would be a very logical thing to do, because it's doing therapy, it's putting someone out to a social environment...the therapist can then analyse how you've then been within that group" (Service user)

One case study reflected that service users who are referred to her service are often angry, feeling that they have been 'cut loose' from mental health services. Considering social prescribing as an option alongside other therapies may be a way of addressing this, and providing a more supported transition for those service users who require it.

Staff working within the service also reflected on some of these challenges, related to the point at which referrals are made:

"Now we're beginning to talk about what value it would have to be right at the beginning of people's journey in mental health, that might actually be preventative in actually them coming out of primary care into secondary care...there is a place for actually as well as helping people out of the service one end, actually preventing them coming in" (RDaSH staff)

It was suggested that staff within mental health services had started to recognise the benefits of referring people at an earlier point, and they were starting to try this approach. One factor which had influenced this was the developing understanding of what social prescribing services could offer people in terms of their quality of life. One member of staff from mental health services reflected on the importance of offering social prescribing to a broader range of service users, not just those who are on the verge of discharge:

"We thought well actually it's discriminating unfavourably against perhaps people who were on certain medications, or section 117 after care, it wasn't fair that they couldn't benefit from social prescribing... So we've said lets support them through the process and see what happens, rather than not letting them

start the process because they don't feel that they'll be able to be discharged at the end of it" (RDaSH staff)

Range of activities available

Across our interviews with commissioners, staff involved in the services and patients referred into the services, people consistently agreed that there was a good range of activities available through the current social prescribing model. As one member of staff from mental health services outlined:

"We've always been really, really excited about the mix of things, things that I never knew existed, things that we never would have been able to access before, because we didn't know they were there. The sheer range, the spectrum is really, really wide" (RDaSH staff)

Some service users talked about the way they enjoyed doing something practical, whereas others valued trying something new, learning new skills, or just the opportunity to meet others in a relaxed environment. The needs of patients are so varied, that the importance of achieving a good mix of activities is important.

One reflection was that it was important for the referral process to recognise that people may feel overwhelmed with the choices available, and also they may accept referrals because they don't want to disappoint the advisor or staff member. Although it was acknowledged that the referral process was managed very well, this was a cautionary note which it is useful to reflect upon as the service moves forwards.

However, the importance of promoting the activities appropriately was also discussed by staff and volunteers. It was agreed that VAR staff have to know about a lot of different activities, but it would be useful for there to be more detailed information on certain activities, so that people being referred can make more informed decisions.

Flexibility of the micro-commissioning approach

Both commissioners and staff within mental health services referred to the benefits associated with having a flexible model, particularly when considering the range of activities available to patients. It was clear that the ability of VAR to commission additional/different services for patients, including spot purchase of specific services if a need could be met within existing services, based on individual needs was important. This was highlighted in particular when discussing the needs of patients being referred, as needs could not always be predicted, and it was therefore important that if a need cannot be met within the existing range of services, there would be a way of plugging this gap. It was suggested that this flexibility was vital and should be retained within a future service.

Role of Voluntary Action Rotherham

A common theme in interviews was the importance of the role played by Voluntary Action Rotherham. Staff within mental health services referred to the importance of having an external agency with the level of local knowledge about the voluntary sector.

"They're a bit like the yellow pages. They've got access to so much more information...if we didn't have them, then we'd have to be sourcing the agencies, and you only know what you know..." (RDaSH staff)

People referred into the service reflected on the importance of the VAR advisor, with some suggesting that they played a key role in supporting them to get to their first session. This role is clearly important both in terms of having knowledge, but also the skills involved in supporting people into the service. One interviewee referred to the advisors as almost being like a mentor, stating that he "couldn't speak highly enough of them".

"The VAR [advisor is] almost a mentor, as opposed to just being a notice board, if you like. If all VAR are doing is going there's this, this, this and this, I'm going to go to nothing. But if someone actually takes the time to sit down and learn a little bit about you and say 'OK, what about this?' or 'Have you thought about this?' or 'I really think you might enjoy this'. And some of it can be really good... [the VAR advisor] was wonderful, and I can't speak highly enough of what she did to get me here" (Service user)

A member of staff from mental health services also pointed to the importance of this element of the service being done outside of mental health services. If referrals were somehow made directly into voluntary sector services, then it was suggested that this would reinforce the dependence on secondary mental health services, as opposed to building relationships elsewhere, for example with VAR advisors. This would make it harder to work on quality of life issues.

"We keep offering and reoffering [mental health services], but they won't work, because ostensibly people still go home to a house on their own, and are unhappy in areas of their life, and that's really hard with the demand on our service to actually resolve...there's a distinct difference between depression and unhappiness." (RDaSH staff)

Local context

When discussing the local context within Rotherham, it was suggested that there seems to be a particularly good emphasis on collaboration at the local level, which has enabled the social prescribing model to embed so successfully. This was discussed in terms of the ability to reach a consensus which was in part due to long term, close relationships a very strong culture of open dialogue. It was also suggested that this history of relationships and working together meant that many people seemed to be enthusiastic about the prospect of collaboration:

"It's hard to explain, but people who work in Rotherham are really loyal to Rotherham, and it has got quite a collaborative culture, I think. It seems to be, if you have agreement in Rotherham that something should happen, and if you have agreement with your commissioners or anyone else involved, it can happen, and you can make it happen quite easily I think, if you've got that dialogue and that consensus. There's quite a lot of close relationships, quite a lot of challenging relationships...but all the information is out there, there's a very strong dialogue" (RDaSH staff)

4

The outcomes and impact of the pilot

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

4.1. Well-being outcomes

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

Quantitative data

Quantitative data on service users' progress towards well-being outcomes was collected through a bespoke well-being measurement tool. The tool was originally developed for the Long Term Conditions Social Prescribing Service and adapted for the Mental Health Service. Data was collected by VCSAs from service users when they were first referred to the Service (baseline) with progress measured after approximately 3-4 months (follow-up) as part of a review meeting. It has eight measures associated with different aspects of personal, social and emotional well-being:⁷

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

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

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

Analysis was undertaken on data for 59 service users who had a baseline and follow-up by the end of March 2016. An overview of this analysis is provided in Figures 1-3 and discussed below.

Overall, **93 per cent of service users made progress against at least one outcome** and 64 per cent made progress against four or more of the outcomes. Figure 4.1 shows that the average (mean) score for each outcome measure improved significantly between baseline and follow-up, with greatest progress made against the 'work, volunteering and social groups', 'feeling positive' and 'lifestyle' outcomes.

Figure 4.2 provides an overview of data for service users who provide a 'low' score⁸ for each outcome measure when they first engaged with the service. Analysis of low scores provides an indication of how effective the service has been at improving outcomes for service users in the particular aspects of well-being where their needs are greatest. As with figure 4.1, this shows that the average (mean) score for each outcome measure improved significantly between baseline and follow-up, with greatest progress made against the 'work, volunteering and social groups', 'feeling positive' and 'lifestyle' outcomes.⁹ However, it also shows that for service users with a 'low' baseline score for a particular outcome the average improvement was greater than for the sample as whole - 1.20 compared to 0.66 across the eight well-being outcome measures.

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

⁹ The average score for 'Money' also improved a lot, but this a small number of services with recorded a 'low' baseline score (n=10), so this should be treated with some caution,

Figure 4.1: Overview of baseline and follow-up outcome scores for all service users (mean)

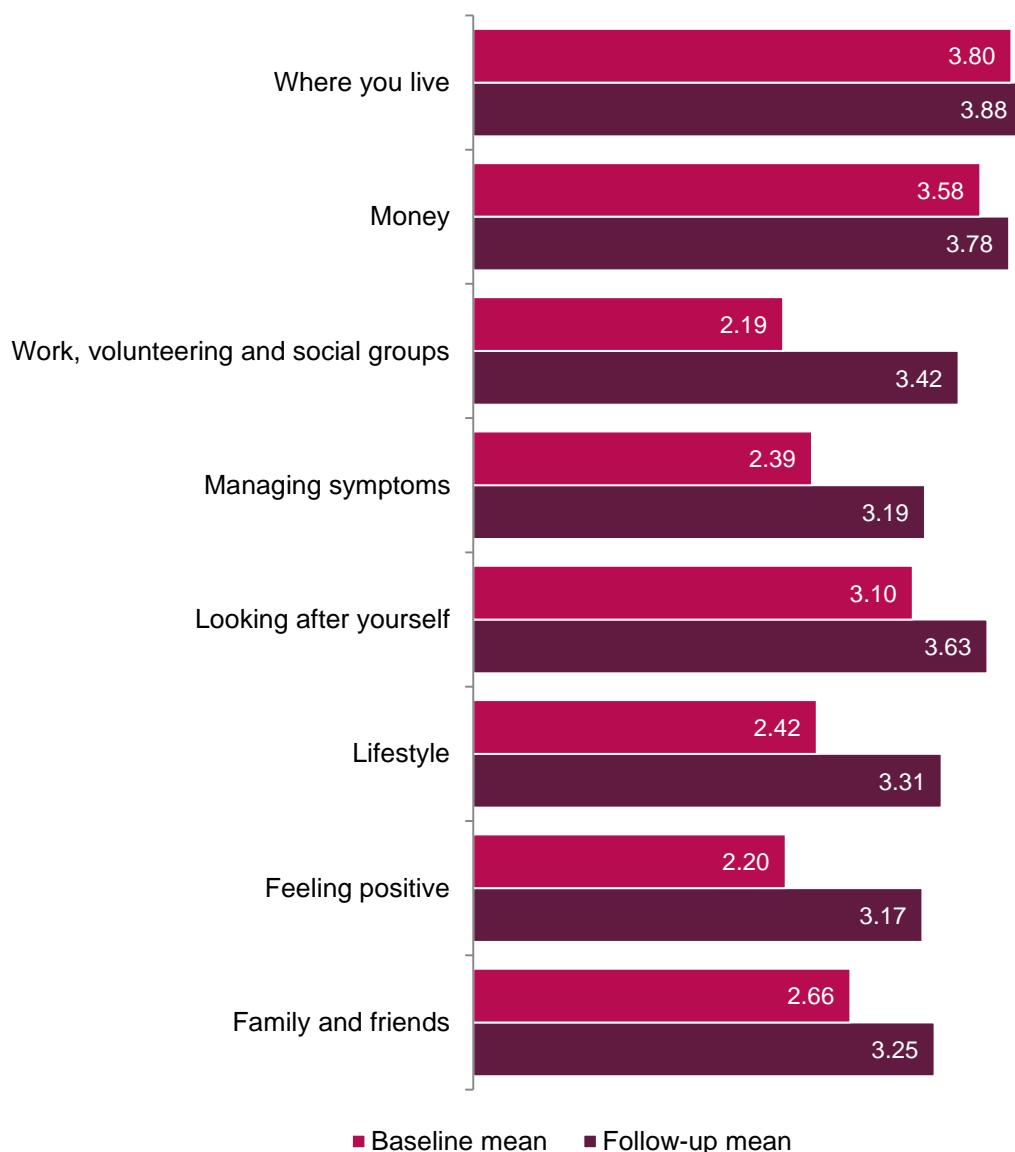


Figure 4.2: Overview of baseline and follow-up outcome scores for service users with a low baseline score (mean)

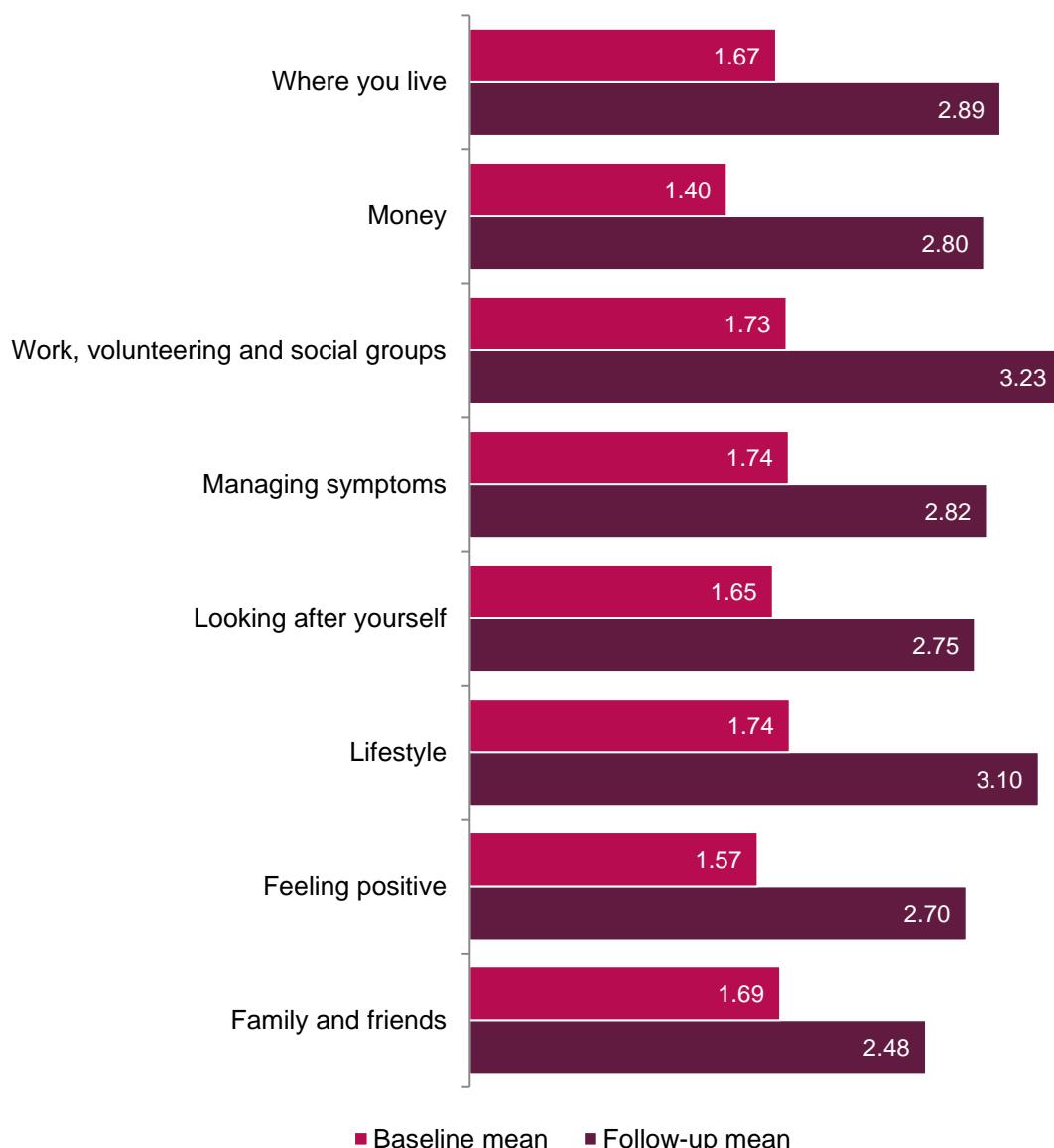
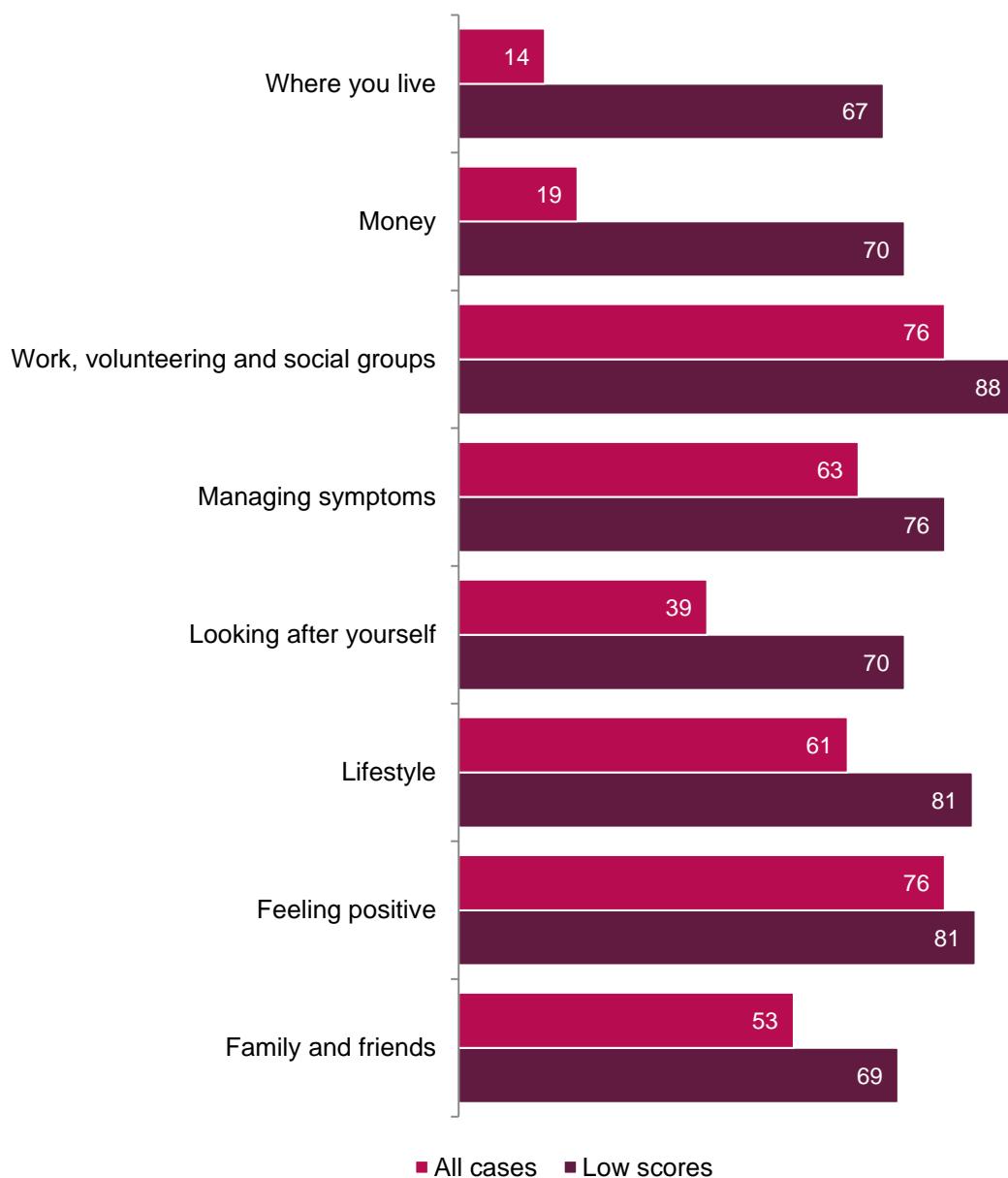


Figure 4.3 provides an overview of the proportion of service users making progress against each outcome, with figures for all cases and those with low baseline scores. This shows that, across all service users, a majority made progress in five outcome areas: work, volunteering and social groups; managing symptoms; lifestyle; feeling positive; and family and friends. For two outcome areas - 'work, volunteering and social groups' and 'feeling positive' - more than three-quarters made progress. Across service users with a 'low' baseline score the picture was even more positive. A majority of at least two-thirds made progress against each outcome and more than three-quarters made progress against the 'work, volunteering and social groups', 'feeling positive', 'lifestyle' and 'managing symptoms' outcomes.

Figure 4.3: Proportion of service users making progress against each outcome (per cent - all cases and low baseline scores)



That outcome progress was greatest and most likely for the areas where the mean baseline scores were low, and where they were higher proportions of services with a 'low' baseline score, is positive and suggest that **social prescribing is effective at meeting the most acute well-being needs** of mental health service users.

Qualitative data

Qualitative data on mental health service users' outcomes was collected through interviews with participants and service providers during three in-depth service level case studies. Interviews with key stakeholders also revealed mental health practitioners views about how social prescribing was benefiting the service users they were involved with. From these interviews a number of key outcome themes emerged. These are summarised below.

Patients from across the three services discussed the broad range of benefits they felt from attending.

A way of getting out of the house

People discussed the significance of the services in terms of providing them with a focus for the day/week, as is reflected below:

"It made a big difference to me because it got me out during the day." (Service user)

A volunteer, who had also been a service user, reflected on how the importance of the service in terms of providing this kind of motivation:

"It makes a huge difference to us when, you know, you have actually got something to get out of bed for in the morning" (Volunteer and service user)

Provides something to look forward to

Although many service users remembered the anxiety at the start of the journey, many reflected on the importance of having something planned in the week which they know they enjoy:

"I've really enjoyed coming here and doing the little bits of what we've done... it's not only that, it's also the meeting people, and being able to talk to people, and just having something that says 'get out of the house and get down there for 11o'clock. And it's something interesting" (Service user)

And:

"It gives me something to look forward to. I'm here and doing something rather than sat in the house getting more depressed." (Service user)

A way of using and developing skills and developing a new interest

Service users reflected on the importance of having an activity which provided them with an opportunity to learn, as the following quote illustrates:

"I think that was what we all felt before coming here, and what we asked VAR...I think we all said something along the lines of 'I need to think, I need to have my brain firing, and the great thing that this place has done is being able to make your brain fire, and allow you to think, both about the subject, but more importantly around it, and how you feel about stuff, and how other people react to it...and a friendly fairly informal relationship. It's the facilitating of that kind of friendliness or freedom to be ourselves that makes the difference" (Service User)

Prevents isolation

A common theme to emerge from interviews with service users is the extent of the isolation which they feel in their lives beyond the social prescribing service. Because of this, people reflected on the service being a vital aspect of their lives:

"At home...I live in a very isolated way...I wasn't getting to see people, I had no activity during the day. So in that respect it was very helpful, still is." (Service user)

And:

"It's not necessarily one to one therapy, it's that point of getting out your door, getting into a group, it's socialising, it brings something different, more into your life."

Develops confidence

Service providers and service users reflected on the way in which the social prescribing activities had been an important factor in developing people's confidence levels. The following extended extract from an interview with a service provider illustrates this:

"There's one chap...the first contact we had was with his sister, and his sister gave us a little bit of background about him, in that he wouldn't go out of the house, he wouldn't use the telephone, he just won't go out and do anything. And he was referred to us, and I then rang his sister...so he came down and she stayed with him the first session, and we did the basics, he went home, and she rang back, she said, 'he really liked it and he wants to come again, but I'm not available next time, can we arrange transport?'...and he came next time, and every time he's come now, he comes on his own, he never used to come out. He's now had a telephone put in at the side of his lounge chair, he answers the phone to me now. And he's now part of this other group that have got this little thing going where they all bounce ideas off each other... He's come out of his shell, he's got a bit of confidence, he's mixing with other people. And what was really nice was that, his sister rang up after the second or third session, she said, 'I've had this bottle of champagne from however number of years ago, that we've been saving for a special occasion, and I called [service user] up and we had a conversation, and I'm going to open up this bottle of champagne, because he is just changed. That was fantastic" (Service provider)

People seem happier when at the activities

In a number of interviews with service users people reflected simply that they felt happier when attending the services. People were keen to emphasise how important this was:

"You can tell by my demeanour at the moment: I'm happy. I've not always been like that." (Service User)

And:

"One of the things [staff member] does, is she will pick-up very quickly on what our mood is, and she'll adjust the group even within a very quick time, she'll adjust what's being done, she doesn't keep to any ridged rules... and I can certainly say that every time I've been to the group, I've left the group in a happier state than when I arrived." (Service user)

Provides a way of people making new friends and developing support networks outside of the formal mental health services

As well as this long list of benefits expressed by those attending activities, people often reflected on the way in which the services they attended provided them with a 'lifeline', and had enabled them to cope with extremely challenging times which they had experienced recently. Some wanted this evaluation to reflect that they don't know how they would have coped without the support of the social prescribing services:

"If you're feeling down, if you're feeling bad, I have people, they have people" (social prescribing service provider)

This reflects the way in which people have become embedded within services, and have developed significant networks of support within them.

4.2. The impact on discharge from mental health services

The Rotherham Mental Health Social Prescribing Pilot was established with a view improving discharge rates from statutory mental health services and improving extent to which discharge is sustained (i.e. reducing re-referrals to mental health services). As such, the VAR social prescribing team and RDASH have closely monitored service users' progress following their engagement with the service. A 'discharge review meeting' is held around 10 weeks after a service user begins receiving support during which an assessment is made about the *potential for and likely timescales* of discharge. By the end of March 2016 72 discharge review meetings had been held, **39 service users had been discharged from mental health services (54 per cent)**, and two discharged service users had been re-referred¹⁰.

This is clearly very positive evidence from the first year of the service: the first cohort of patients referred to the pilot and been supported by secondary mental health services for between 5-20 years with being discharged successfully. However, it will be important to monitor patterns of discharge over a longer period to fully understand the impact. These patterns should also be compared to broader RDASH discharge data for comparative purposes. In particular, the discharge rates and sustainability of discharge for mental health service users should be compared to previous years for these cohorts, and to other cohorts engaging with mental health services.

In the qualitative work a number of interviewees discussed the issue of focusing too much on discharge numbers. It was understood that this was a central motivating factor behind establishing the pilot, however, people wanted to emphasise the wide ranging benefits to people's quality of life, regardless of whether they were ready to be discharged from mental health services.

"A lot of ours have gained benefit from going through social prescribing, but the discharge back to G.P. at the end is just a step too far. But that's not to say that they've not gained benefit from begin in the process, and finding out more about what goes on in the community, and being engaged in more meaningful occupations. So although the end result probably from a social prescribing point of view might not have been what was wanted, because obviously discharge back to the G.P. was the ideal, I don't think the people that have been through it and haven't been discharged back, I do feel that they've benefited as well" (RDASH staff)

As one member of staff from mental health services reflected, those involved in establishing the service focused a great deal on discharge, but this proved to be problematic:

"I think probably when we were engaging staff with it, we were too focused, on reflection we were far too focused on the notion of discharge. And we made it all about that, really, and that was the wrong thing to do because actually it's about much more than that...because that's a massive problem that we have...so it was always a premise of this scheme that it would help support a sustained discharge, but I think the problem with that is because it was construed as though we were putting people under pressure to discharge...which is not the case really, but I can understand why it felt like that..." (RDASH staff)

It was agreed that in the long term, sustained discharges were important, but there may be ways of recognising the shift in reliance on mental health services, or a

¹⁰ The two re-referred service users had attended the initial assessment but had not engaged with SPS activities.

reduction in need, even if full discharge isn't possible. It was suggested that a broader emphasis on quality of life issues would paint a better picture of the impact that the social prescribing service was having on individuals as well as services. One member of staff emphasised the significant step-down in services even when full discharge wasn't a possibility:

"The fact that there's people that we're not able to discharge, but actually they still probably need us less as a result of being through this scheme...they still have a better quality of life and less reliance on services as a result of going through [social prescribing]. So there needed to be a broader emphasis on general quality of life for the individuals that we referred as opposed to just facilitating them out of a dependence on secondary services" (RDaSH staff)

4.3. The wider benefits of social prescribing for mental health service users

The evaluation also found **a range of evidence about the wider social benefits of the pilot**. This evidence emerged from both qualitative and quantitative data and is discussed in more detail below.

Quantitative data

Voluntary Action Rotherham is monitoring a number of service user outcomes in addition to the well-being measures discussed earlier in this chapter. These include whether the found employment whilst engaging with social prescribing, whether they took part in training, whether they volunteered, whether they took-up physical activity and whether they continued to be involved in voluntary sector activity once their engagement with social prescribing was complete. Analysis of this data shows that, of the service users whose engagement with social prescribing was completed by May 2016 (n=94):

- three had found employment
- 24 had engaged in training or education
- 14 had volunteered
- 25 had taken-up activity to improve their physical health
- 40 had continued to engage in voluntary sector activity once their social prescription had ended.

Qualitative data

Through the qualitative interviews three themes emerged about the wider benefits of the pilot: service user progression, the improved relationship between mental health services and the voluntary sector, and the importance of peer support.

Sustaining involvement in voluntary activity beyond the social prescribing pilot

An important feature of all three case studies explored within this evaluation was each had found a way of enabling patients at the end of their social prescribing referral to sustain involvement in the group, often with the help of VAR. In many cases, people had progressed to become volunteers supporting the ongoing work of the organisation.

In one case, a group of service users were in the process of setting-up a group which would be semi-independent, continuing to attend the main activity as a group, as well as being able to do additional activities independently from the service provider. Staff from the provider organisation and VAR were supporting this process.

"The other service users that are now finishing wanting to start a group and wanting to go forward and do something for themselves but with us as part of it." (Service deliverer)

In another case, the provider organisation had set-up another activity session for those who had finished their referral period, but patients were asked to donate towards the cost of this session.

One service deliverer reflected on the way in which service users were starting to shape the group:

"The fact that the user group themselves are making things happen is a major strength I think, because it's showing that they've developed interests, or have worked on interests that they've already got, and been able to take the further step, but within the supported environment, which is absolutely brilliant because it's giving them another dimension to what they were doing" (Social Prescribing service provider)

One volunteer reflected on the progression they had made, from service user, through the volunteer, and their aspirations for the future:

"This is a brilliant way of getting back into work, I had a very bad experience with my last job, and this was a very good way of getting used to working again... one day I'll have to move onto something that comes with a wage, which will be very sad because I'd love to stay here" (Volunteer)

Another service talked about the possibility of setting-up a separate group for those who had completed their social prescribing period, but wanted to remain involved in the activity:

"I have absolutely no problem, if I have too many people that are on the main element of the programme, running a session where the previous group come, that's fine, because we're a social enterprise, that door's always open...everybody's welcome, and we have resources, we've got whatever, you come and you do" (Service provider)

Organisations are thus faced with a challenge of how to accommodate additional sessions. All service providers expressed their aspirations to continue to support service users, and a sense of responsibility to continue to support people:

"My opinion is the worst thing you can do after helping people to get back part of what they feel they're missing, is to say 'I've done that now, you're cut free' (Service provider)

One note of concern expressed by one ex-service user, who had since become a volunteer, was that they were worried about the impact that volunteering might have on his welfare benefits. He reflected that he had been warned that if he undertook too much volunteering, he would be put back onto job seekers allowance, and this was a cause of anxiety:

"I've been officially warned... I've now been warned that if I do too much of it, I'll be taken off ESA and put back on job seekers, because of the fact that I'll be classed as fit for work. That is a big worry at the back of my mind at the moment, the finance side." (Volunteer)

Relationship between mental health services and the voluntary sector

It was suggested by staff within mental health services, but also staff within voluntary sector organisations involved in the service, that the pilot had raised awareness about how the sectors could work together more effectively. Prior to the Social Prescribing service, any referrals into voluntary sector agencies were based on individual, ad-hoc knowledge of individual staff members, whereas the more structured process was enabling staff to learn about different activities available.

One issue which has arisen within the pilot phase has been the need to raise awareness of how mental health services operate, and issues relating to managing risk with the broad range of service users being referred. It has been acknowledged that training and awareness raising sessions are needed about concerns surrounding risk. This is an ongoing and evolving piece of work.

The importance of VAR within the process was highlighted, as a key point of reference and support to find out more about local services and activities available. It was also stated that it was important that the management of the Social Prescribing Service was done outside of mental health services, in order to enable individuals to start to build relationships outside of mental health services.

The importance of continuing to foster these relationships between sectors was highlighted by mental health staff, in terms of the quality of services, but also in terms of the importance for the future of mental health services, as one emphasised,

"I think they are really beginning to understand that if we're not going to implode, we've got to have a relationship with the third sector...but very, very specific to social prescribing itself and its character" (RDaSH staff)

Peer support

Supporting people to improve their peer support networks was one of the key aims of the pilot. It was seen as an important way of reducing social isolation and helping people become more resilient and able to cope with setbacks in life without support from mental health services. Importantly, patients suggested that an important impact of the social prescribing mental health pilot has been the way in which the group activities have enabled relationships between patients to develop, and informal peer support to be established. One service provider referred to his experiences of this:

"Especially with the older service users it's, 'oh what medication are you on? Oh I tried that and...' it's sharing stories, not only the current situation, but a lot of them, it's what they've done in the past, where they've worked, people they've worked with, countries they've lived in. You know, it's amazing, you see a person walk through the door who physically might be uncomfortable even walking, but you get them sat down, and the atmosphere just changes, and they start totally opening up about what they've done...It can be humbling" (service provider)

People interviewed reflected on the significance of learning from each other's experiences, all bringing different things 'to the table' and supporting each other. The relaxed nature of the services contributed to this.

"I might not want the world to know something, but I do know that these guys will quite happily pick up on it almost, without me having to say anything" (service user and volunteer)

And:

"A lot of people with our kind of issues become insular, but one of the whole points of [social prescribing] is to get you out and to meet people, so as far as we're concerned, to have that group outside the structure of anything is everything to us, and that in a way is the ultimate outcome" (Volunteer and service user)

4.4. The fiscal, economic and social value of social prescribing for mental health service users

Fiscal and economic value

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

Drawing on the wider evidence, it is possible to estimate that each service user discharged from secondary mental health services who would not have been discharged without engaging with social prescribing, and for whom discharge is sustained for 12 months, there will be a fiscal and economic benefit of £4,281 per year.¹¹ This means that up to 47 service users will need to achieve a sustainable discharge each year if the Pilot is to create fiscal and economic benefits greater than the costs of delivering the service (i.e. a positive return on investment). However, if discharge can be sustained for more than a year then the number of service users required to achieve a positive return on investment would reduce. This highlights the importance of monitoring discharge figures, including the sustainability and additionality of discharge, over an extended period to properly understand the fiscal and economic benefits of social prescribing for mental health service users.

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

¹¹ This is the **average annual fiscal and economic costs** per adult suffering from any type of mental health disorder (excluding dementia). The **fiscal value** component of this cost is the average annual cost of service provision to the NHS (£757), local authority (£98) and criminal justice (£15). The **economic value** comprises lost earnings (£3,501 per person on average, at 2007-08 prices) and costs falling to informal carers (an estimated £136 per person). Other social costs (e.g. from reduced well-being) are not monetised. These figures are drawn from the [New Economy Unit Cost Database](#) and based on evidence collected in the King's Fund report: [Paying the Price: the cost of mental health care in England to 2026 \(King's Fund, 2008\)](#)

Social value

It is possible to assess the social value of the Mental Health Social Prescribing Pilot by using financial proxies to provide a monetised estimate of social return on investment (SROI) drawing on analysis of the well-being outcome data discussed in earlier in this chapter. This approach to monetising well-being draws on social value work undertaken by the New Economics Foundation and New Economy Manchester¹² to value the subjective well-being benefits associated with social interventions and has been applied in the Evaluation of the Rotherham Social Prescribing Service for people with long term conditions.

In this approach well-being is equated with mental health to monetise the social value created. Analysis by the Centre for Mental Health¹³ placed a cost on mental illness through the use of QALYs (Quality Adjusted Life Years), derived from a measure of health-related quality of life. Their analysis identified the average loss of health status in QALYs from a level-three mental health problem (a severe problem - 0.352 QALYs) and valued this by using the NICE (National Institute for Health and Care Excellence) cost effectiveness threshold of £30,000 per QALY. Equating well-being with mental health therefore provides an overall well-being valuation of £10,560 per year ($0.352 \times £30,000$). As the Rotherham Social Prescribing Service do not use a recognised QALY-based tool (such as EQ-5D), the well-being outcome tool was used as a proxy measure of well-being and health-related quality of life.

Methodology

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

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

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

Table 4.1: Allocation of financial proxies

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

¹² Cox, J et al (2012) *Social Value: Understanding the wider value of public policy intervention*. New Economy Working Paper 008.

¹³ Centre for Mental Health (2010) *The economic and social costs of mental illness*, (June 2003, updated October 2010).

An estimate of the well-being value created

An overview of the estimated well-being value created for users of the Mental Health Social Prescribing Pilot is provided in Table 4.2. The total value was calculated by multiplying the per-user value by the total number of users substantively engaged by the Service across the first year of operation (n=136).

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

Outcome area	1: Valuing all outcome change		2: Valuing low to high outcome change	
	Per Service user value	Total value	Per Service user value	Total value
Family and friends	£157	£21,299	£336	£45,641
Feeling positive	£255	£34,687	£559	£76,068
Lifestyle	£233	£31,644	£515	£69,982
Looking after yourself	£139	£18,865	£291	£39,555
Managing symptoms	£210	£28,601	£604	£82,153
Money	£54	£7,303	£89	£12,171
Where you live	£22	£3,043	£89	£12,171
Work, volunteering and social groups	£327	£44,424	£694	£94,324
Total	£1,396	£189,865	£3,177	£432,065

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

- Valuing all outcome change produced an estimated total well-being value of £190,000
- Valuing low-to-high outcome change produced value of £432,000

These values can be compared with the costs of delivering the Service to provide an estimate of the annual return on investment provided (Table 4.3). This demonstrates that the estimated social return on investment from well-being benefits for the pilot was between £0.96 and £2.19 (between ninety six pence and two pounds and nineteen pence for each pound invested). This means that there is likely to have been **a positive social return on investment based on the well-being benefits experienced by service users resulting from the pilot.**

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

No of Service users engaged	Input costs	1: Valuing all outcome change		2: Valuing low to high outcome change	
		Total value	ROI	Total value	ROI
136	£197,150	£189,865	£0.96	£432,065	£2.19

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Conclusion

This report has provided the main findings of an evaluation of the Rotherham Social Prescribing Mental Health Pilot that was delivered in partnership by Rotherham, Doncaster and South Humber Foundation Trust (RDASH) and a group local voluntary sector organisations led by Voluntary Action Rotherham on behalf of NHS Rotherham Clinical Commissioning Group (CCG). The evaluation focussed on the first year of the Pilot (April 2015-March 2016). The main findings are as follows.

1. The pilot has engaged with than 130 users of secondary mental health services in Rotherham

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

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

More than 90 per cent of service users made progress against at least one well-being outcome measure and more than 60 per cent made progress against four or more measures. Service users who provided an initially low score against each outcome measure made the greatest amount of progress and the areas where progress was most marked included 'work, volunteering and social groups', 'feeling positive', 'lifestyle' and 'managing symptoms'. These findings were reinforced by qualitative case studies which found that social prescribing provided service users with something to look forward to that prevented isolation, increased confidence and improved happiness in a way that developed and utilised skills in new and interesting areas.

3. A range of wider benefits also emerged from the pilot

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

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

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

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

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

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

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

It is estimated that the well-being benefits experienced by service users equate to social value of up to £432,000: a social return on investment of £2.19 for every £1 invested in the pilot.

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

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

Given these important local strategic benefits from the Rotherham Social Prescribing Mental Health Pilot the commitment from RDASH and the CCG to explore potential for wider roll out of social prescribing within secondary and primary mental health care services is an important development that should enable the benefits identified to be realised more broadly than the current model.



Evaluation of the Rotherham Mental Health Social Prescribing Pilot

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