Sheffield Hallam University | **Centre for Regional Economic and Social Research**
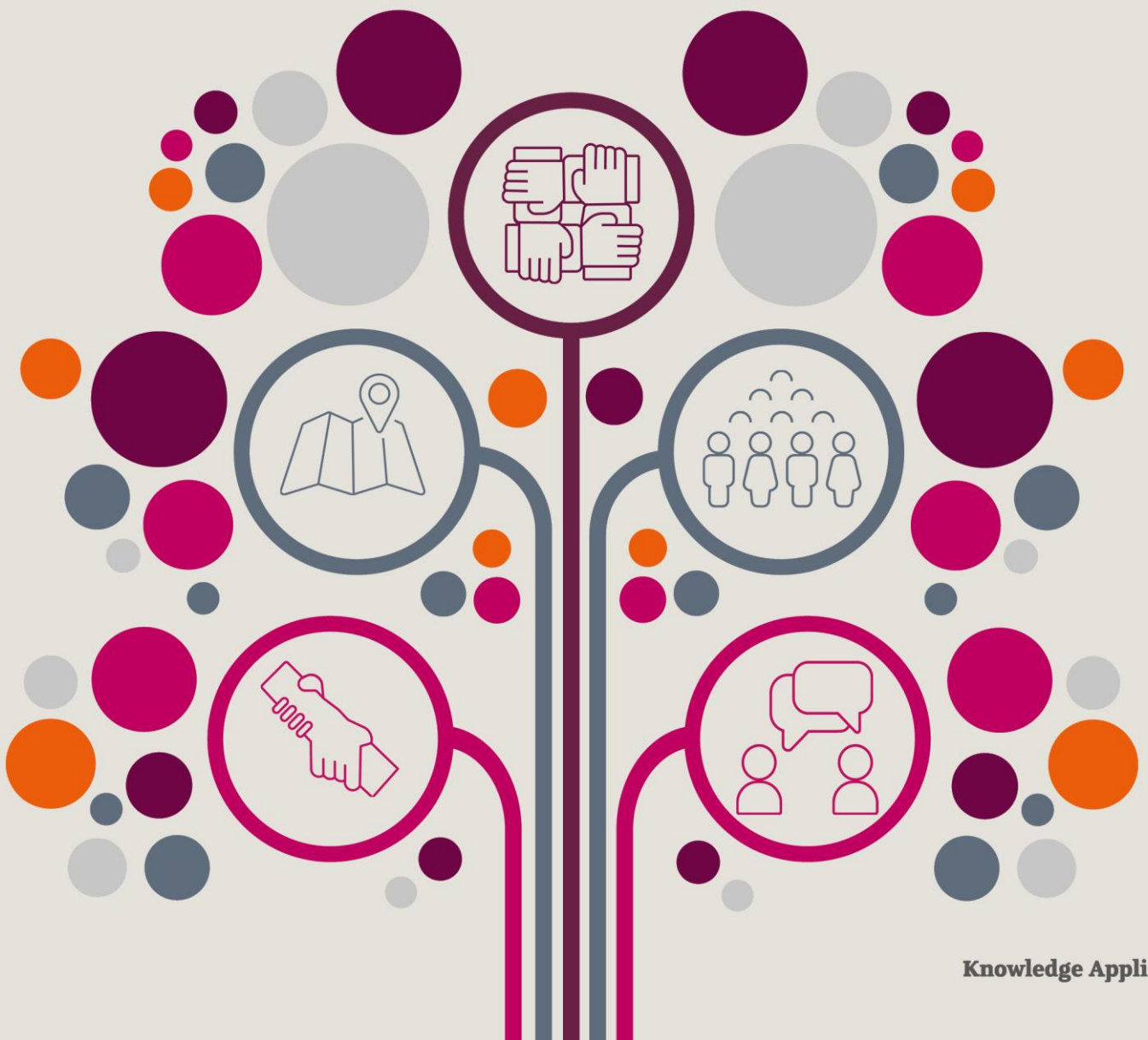
Evaluation of the Rotherham Social Prescribing Service: Data and Insights 2016/17-2021/22

August 2024

Knowledge Applied

Evaluation of the Rotherham Social Prescribing Service: Data and Insights 2016/17-2021/22

Author(s):

Chris Damm

Chris Dayson

August 2024

Contents

Introduction

This is latest report from a long-term Evaluation of the Rotherham Social Prescribing Service (RSPS) being undertaken by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University.

This report focuses on the 'Long-Term Conditions' component of the RSPS[1] which is commissioned by NHS Rotherham Clinical Commissioning Group (CCG) as part of GP-led Integrated Case Management.

It is delivered by Voluntary Action Rotherham (VAR) in partnership with 19 local voluntary and community organisations (VCOs). The service aims to increase the capacity of GPs to meet the non-clinical needs of patients with complex long-term conditions (LTCs) who are the most intensive users of primary care resources. Specific support for the carers of case-managed patients is also provided.

At its core, RSPS is a voluntary and community sector (VCS) liaison service for the whole borough which:

- Enables patients and their carers to access support from local VCS organisations.

- Contributes a VCS perspective to the assessment of needs and care planning for patients referred to multi-disciplinary Integrated Case Management Teams (ICMTs).

- Facilitates the development of new community-based services to fill gaps in provision, and funds additional capacity within existing VCS to meet the increase in demand created by RSPS.

The Service was first commissioned as a two-year Pilot in 2012. In 2014-15 it was re-commissioned for a further year as part of Rotherham's multi-agency proposal to the Better Care Fund, with an additional three years of service provision commissioned in April 2015 and then again in April 2018 by the CCG. RSPS is currently fully funded by NHS South Yorkshire (the South Yorkshire Integrated Care Board -SY ICB) through Rotherham place commissioning until March 2027.

The annual funding agreement covers the core cost of delivering RSPS alongside a 'micro-commissioning' budget to procure a 'menu' of VCS activities that have been specifically developed to meet the needs of Service users.

---

[1] The RSPS also includes a community mental health service component, delivered in partnership with Rotherham Doncaster and South Humber NHS Foundation Trust (RDASH). The evaluation findings for this are published separately.

A core team consisting of a Service Manager and eight Voluntary and Community Sector Advisors (VCSAs) is employed by VAR. The Service Manager oversees the day-to-day running of the Service, including management of service commissioning and acting as a liaison between VCS providers and wider NHS structures. The VCSA role provides the link between the Service, wider voluntary and community sector] and GP Practices.

The VCSAs] receive referrals from GP practices of eligible patients and carers and assess their support needs before referring them on to appropriate VCS services (commissioned and non-commissioned). Assessments typically take place during a home visit or on the telephone where the VCSA will talk through the Service user's needs and discuss the options available to them through Social Prescribing. VSCAs also form part of the ICMT and attend meetings when Service users are discussed.

This report provides **an in-depth review of data for the Long-Term Conditions (LTC) component of RSPS for the 6-year period April 2016-March 2022.**

How many people have participated in the service?

Between April 2016 and March 2022, 4,840 patients received an initial assessment from a Voluntary and Community Sector Advisor. The total number of assessments completed was 6,435, since some patients were referred more than once over this time. Social prescribing assessments have remained reasonably consistent each year, with a modest dip in 2020-2021, likely related to the Covid-19 pandemic and lockdown measures.

Figure 1: Number of assessments timeseries
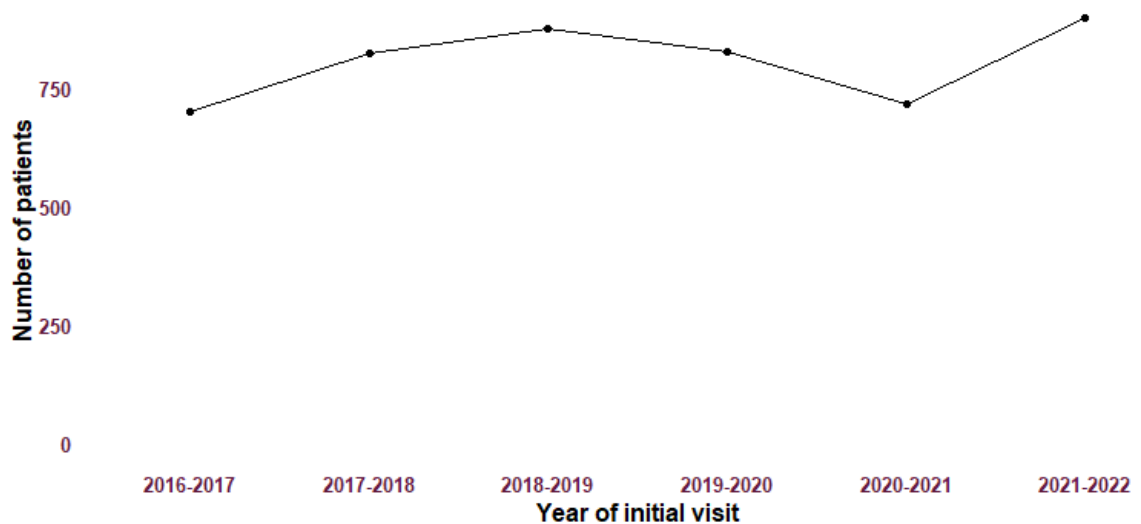
Waiting times also dipped in 2020, again potentially due to changes in how the scheme operated during Covid-19 related lockdowns. Overall, they have remained consistently at or below the two-week level.

Figure 2: Average waiting times timeseries
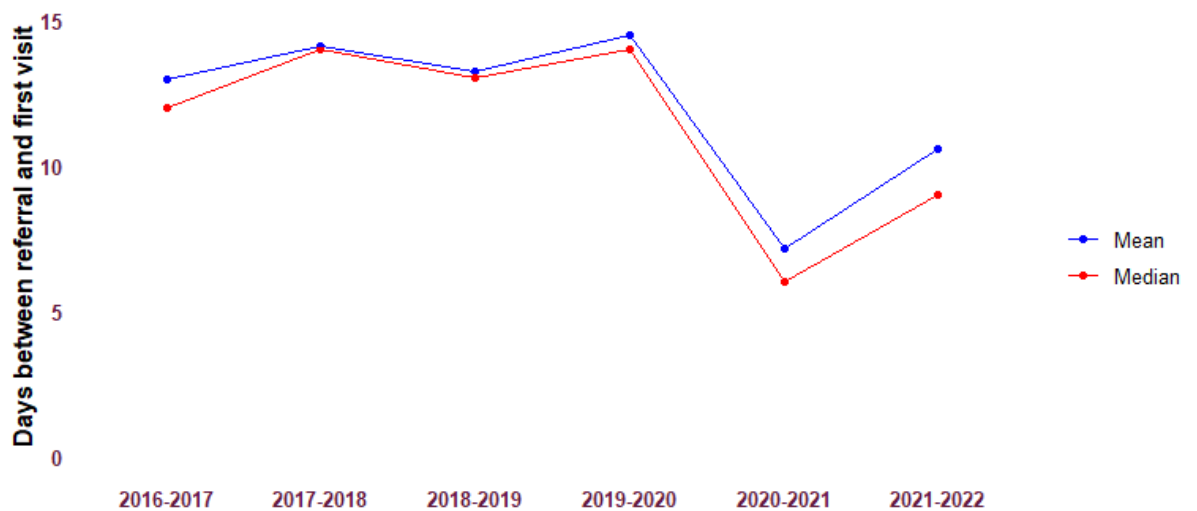
2.1. Number of referrals per patient

72.7 per cent of 2,936 patients were referred to the social prescribing service multiple times – sometimes patients do not take up an assessment when they are first referred and some patients receive more than one assessment (for example if a previous assessment did not result in an onward referral being taken-up). The mean number of referrals per patient was 2.7 and the median was 2.0.

Figure 3: Number of referrals per patient
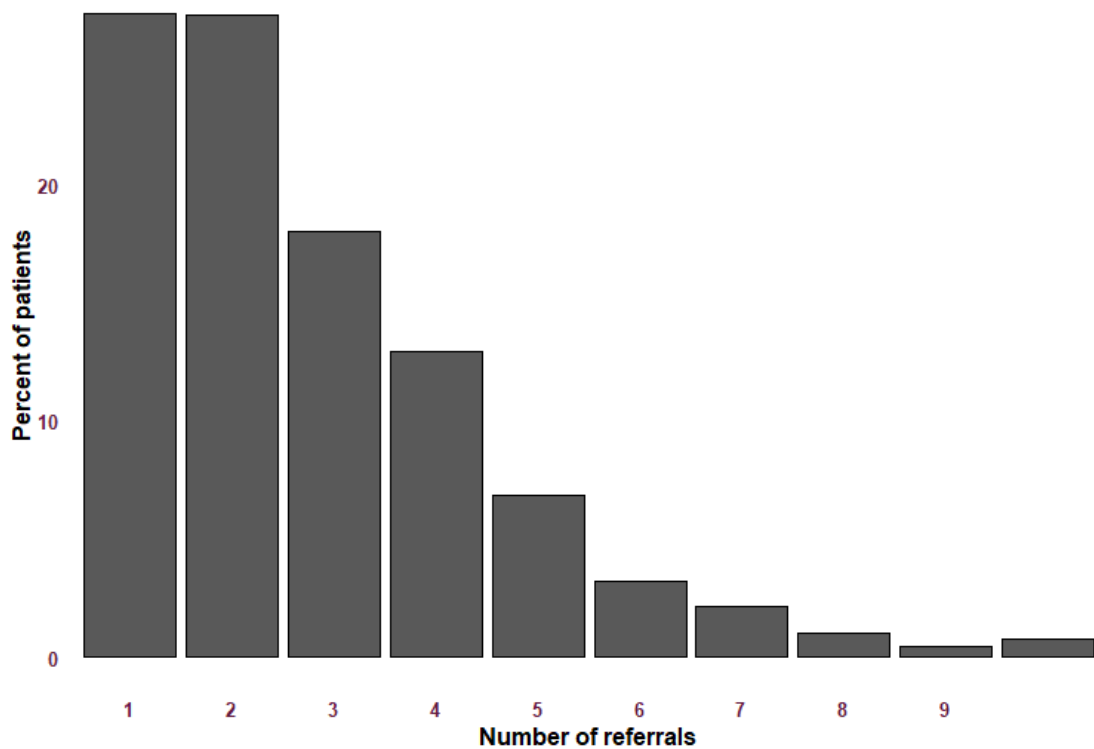
2.2. Onward referral start dates

The number of new services started by patients has remained relatively stable, although with slightly lower numbers in 2020, likely reflecting the COVID-19 pandemic. There is a cyclical element to the data, with peaks seen every April. This is due to end-of-contract year. Patients still open with a provider at the end of March are re-opened on the providers' new SLA starting in April. Hence, they are transferred to the new contract and appear as new referrals, but are actually termed 'transfers'.

Figure 4: Number of services started each month
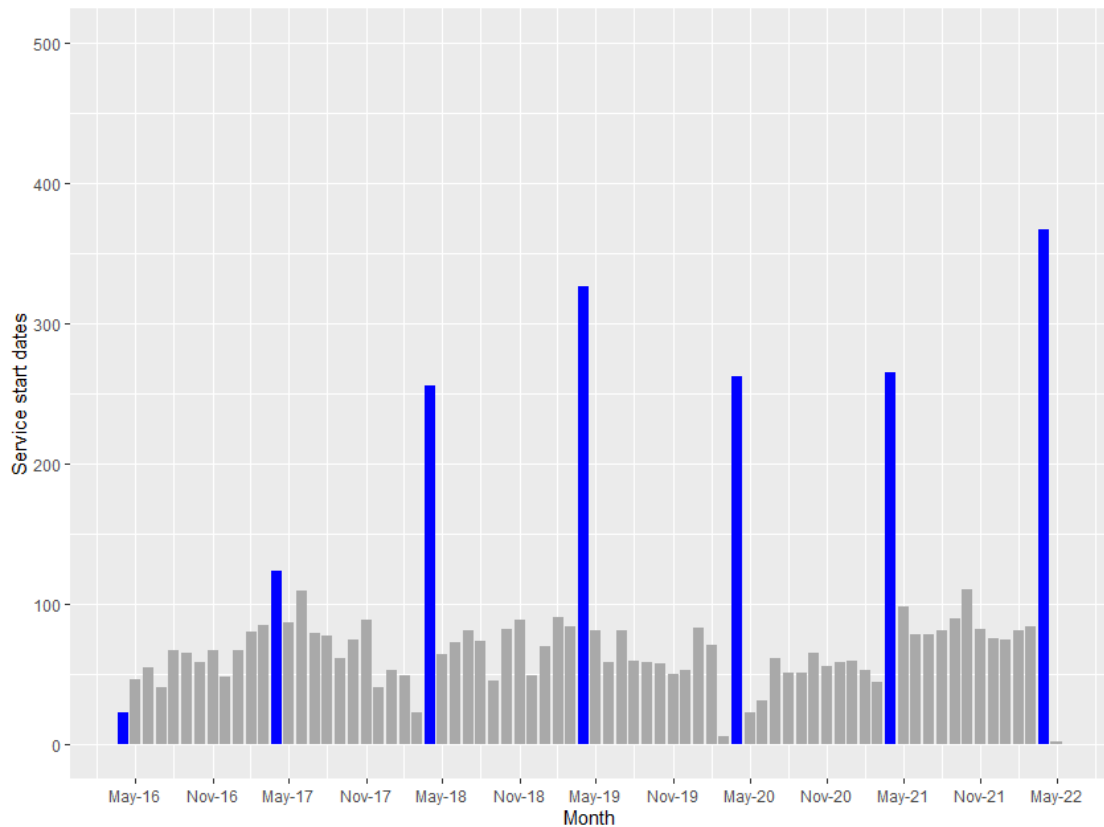
What do we know about participants?

This section provides an overview of patients referred under the RSPS referral patterns between April 2016 and March 2022.

3.1. Patient age

Figure 5: Age category histogram
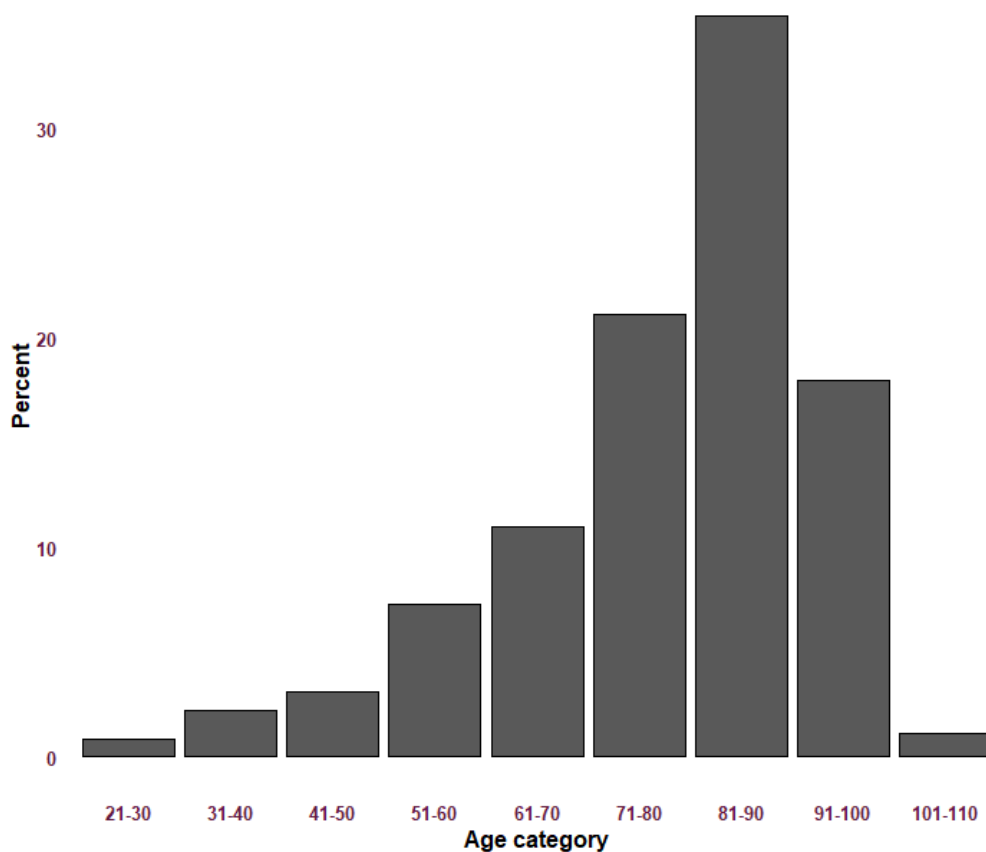
Patients referred to social prescribing tend to fall within older age brackets. The median age is 82, which means that approximately 50 per cent of referrals are over this age and 50 per cent are under. 19.1 per cent of referrals are over 90.

Table 1: Age category frequencies

Age category	Frequency	Percent
21 to 30	37	0.8
31 to 40	107	2.2
41 to 50	149	3.1
51 to 60	354	7.3
61 to 70	529	11
71 to 80	1,017	21.1
81 to 90	1,703	35.4
91 to 100	869	18
101 to 110	52	1.1
Total	*4,817*	*100*

Not including 23 patients with either missing or invalid data

The percentage of patients in the very oldest age groups, however, has been decreasing over time. There are somewhat fewer patients over 80 or over 90 years old in 2021-2022 compared to 2016-2017.

Figure 6: Age category time series
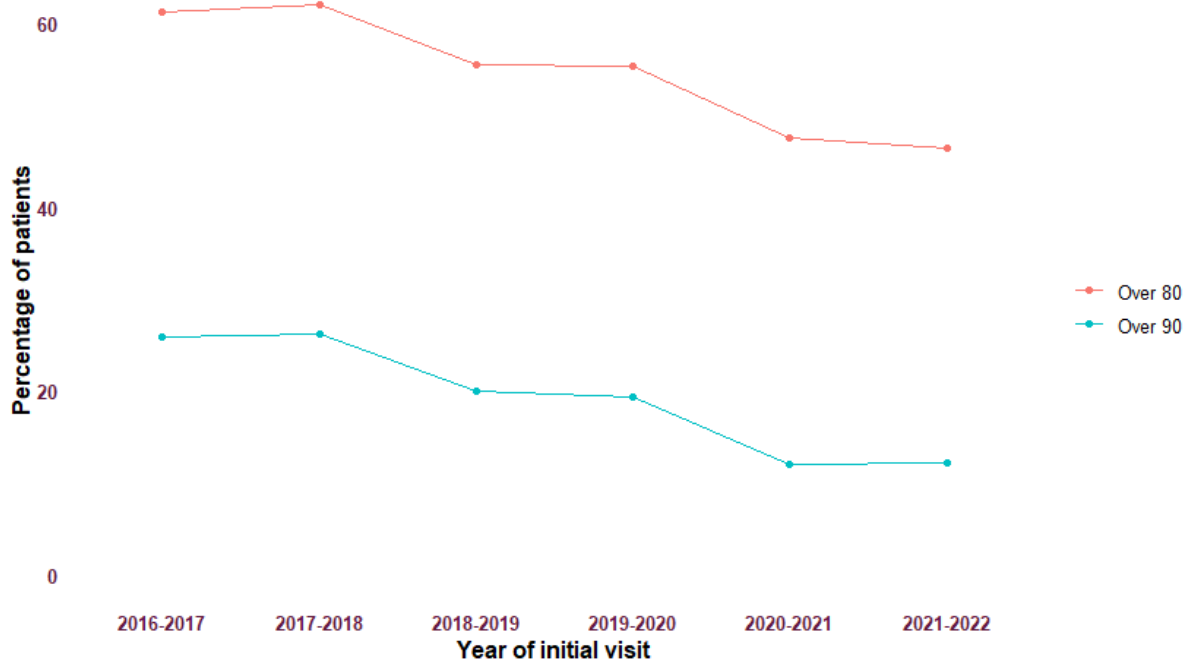
3.2. Gender

There are substantially more women than men being referred under the social prescribing programme than men. Nearly two thirds of all referrals so far have been women, and this has remained consistent across all years of the service.

Table 2: Gender category frequencies

Gender	Frequency	Percent
Female	2,926	60.5
Male	1,912	39.5
Total	*4,838*	*100*

Not including two patients with either missing or invalid data

3.3. Ethnicity and language

96.8 per cent of patients were White British, with Pakistani as the next most common ethnicity, accounting for 2.5 per cent of patients. Other ethnicities combined accounted for just 0.7 cent of patients. A large majority (97.7 per cent) of patients indicated that English was their preferred language. The next most common language was Urdu, recorded by 1.5 per cent of patients.

Table 3: Ethnicity frequencies

Ethnicity	Frequency	Percent
White British	4,489	96.8
Pakistani	116	2.5
Other ethnicity	33	0.7
Total	*4,638*	*100*

Not including 202 patients with either missing or invalid data

Table 4: Preferred language frequencies

Preferred language	Frequency	Percent
English	4,037	97.7
Urdu	60	1.5
Other language	36	0.9
Total	*4,133*	*100*

Not including 707 patients with either missing or invalid data

3.4. Geography

The understand how access to the social prescribing service varies according to geography we initially explored patient location by postcode district. The highest concentrations of patients are unsurprisingly concentrated in the Rotherham area, with a higher concentration of patients in areas away from the town centre such as Dinnington, Kiveton Park and Rawmarsh (S25, S26 and S62).

Figure 7: Number of referrals per 100k population within postcode districts
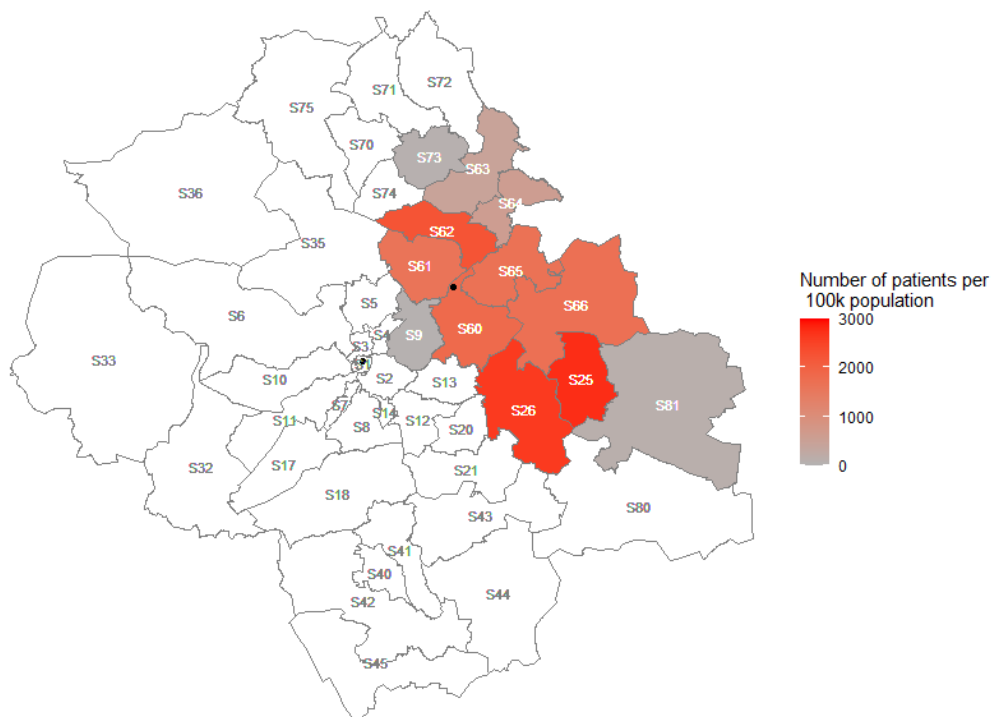
More granular geographical analysis was possible through the use of aggregate data provided by VAR, who have access to the full postcode for each patient. Specifically, in enabled us to explore using the Indices of Multiple Deprivation (IMD) whether there was any relationship between the level of deprivation in each postcode and the number of patients referred to social prescribing. IMD classifies postcodes into 10 deciles based on relative disadvantage, with decile 1 being the most deprived and decile 10 being the least deprived. Table 5 shows this for RSPS patients for each year 2016/17-2021/22.

Table 5: IMD decile of RSPS patients 2016/17-2021/22

	IMD Decile									
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
2016-2017	26%	13%	14%	10%	5%	9%	11%	6%	5%	N/A
2017-2018	25%	16%	12%	10%	4%	9%	12%	6%	6%	N/A
2018-2019	29%	14%	12%	10%	5%	8%	11%	7%	5%	N/A
2019-2020	25%	16%	13%	9%	6%	8%	11%	7%	5%	N/A
2020-2021	31%	12%	13%	9%	5%	8%	12%	6%	4%	N/A
2021-2022	27%	12%	15%	8%	6%	9%	12%	6%	5%	N/A
Overall	**27%**	**14%**	**13%**	**9%**	**5%**	**9%**	**11%**	**6%**	**5%**	**N/A**

This shows that for each year 2016/17-2021/22 the largest proportion of RSPS patients – more than a quarter – lived one of the 10 per cent most deprived areas of the country and around one in five lived in one of the 20 per cent most deprived areas of the country. This is important in the context of addressing health inequalities. Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. The Core20 refers to the 20 per cent most deprived areas of the country according to the IMD. Overall, these data show that RSPS is well placed to deliver on the NHS ambition to address health inequality by supporting significant numbers of people in the Core20 target group.

4

Types of referrals and providers

4.1. Types of referrals

Four different types of referrals were made as part the service.

- Grant Providers: 68.4 per cent of all referrals were made to VCS organisations who had been commissioned under the social prescribing scheme.

- Other VCS: 11.9 per cent of referrals were made to 106 VCS organisations (with overlap), but without any payment.

- Non-VCS: 19.5 per cent were made to 57 non-VCS providers/services, again without payment.

- Spot Purchase: a small number of providers received a one-off payment for providing support.

Table 6: Types of referral

Intervention	Frequency	Percent
Grant Provider	7,648	68.4
Other VCS	1,335	11.9
Non-VCS	2,180	19.5
Spot Purchase	21	0.2
Total	*11,184*	*100*

4.2. Main VCS providers

The top five VCS providers of paid-for referrals (accounting for 51.6 per cent of this type of referral) were:

- Age UK Rotherham (15.9 per cent).

- You Ask We Respond (10.9 per cent).

- Crossroads Care (9.2 per cent).

- Active Independence (7.8 per cent).

- Live Inclusive (7.8 per cent).

The top five VCS recipients of non-paid referrals were (accounting for 56.9 per cent of this type of referral):

- Rotherham Community Transport (36.9 per cent).
- Rotherham Sight and Sound (7.2 per cent).
- Stay Put (4.9 per cent).
- Rotherfed (4.2 per cent).
- Alzheimer's Society (3.5 per cent).

The top five non-VCS providers (accounting for 87.2 per cent of this type of referral) were:

- Single Point of Access (48.7 per cent).
- Housing/Contact Centre (14.3 per cent).
- South Yorkshire Fire and Rescue (13.5 per cent).
- Rothercare (8.7 per cent).
- Library Services (2.0 per cent).

4.3. Most common services

Of the referrals to social prescribing grant providers, the most common five services were (accounting for 68.9 per cent of this type of referral):

- Information and Advice Benefits (28.0 per cent).
- Enabling (14.6 per cent).
- Carer Respite (9.17 per cent).
- Advocacy (8.7 per cent).
- Befriending (8.5 per cent).

Out of the referrals to VCS providers outside of the grant scheme the five most common services were (accounting for 66.6 per cent of this type of referral):

- Door 2 Door (34.8 per cent).
- Community Activity Leisure / Social (14.2 per cent).
- Sensory Impairment Service (7.2 per cent).
- Befriending (6.2 per cent).
- Information and advice Other (4.2 per cent).

The five most common services provided by non-VCS providers were (accounting for 57.3 per cent of this type of referral):

- Occupational Therapy assessment (20.3 per cent).
- Grab Rails (10.0 per cent).
- Assistive Technology (9.7 per cent).
- Smoke Alarms (8.8 per cent).
- 24/7 Community Alarm (8.6 per cent).

Patient health conditions

RSPS staff may assign one or more 'flags' to patients notes based on the information provided at the point of referral. 92.8 per cent of patients have at least one flag, and the average number is six. We collected all the flags into categories. The ten most common are shown in Table 7.

Table 7: Ten most common groups of flags

Flag category	Frequency	Percent of all patients with at least one flag from category
Living / caring arrangements	3,368	69.6
Cardiovascular	2,655	54.9
Bone, joint and soft tissue disorders	1,945	40.2
Physical / mobility	1,930	39.9
Mental health / wellbeing	1,573	32.5
Neurological	1,358	28.1
Respiratory	1,170	24.2
Diabetes	1,037	21.4
Social issue	1,010	20.9
Renal	728	15.0

Duplicates have been removed where patients had more than one flag from the same category

The most common type of flag relates to the patients' living conditions, as shown in Table 8. 33.1 per cent of patients were flagged as living with someone else, either a family, friend or carer. 23.5 per cent were flagged as living along with regular support, and a further 9.5 per cent as living alone without regular support. A small number (0.2 per cent) lived in supported living. This leaves approximately a third of patients (33.8 per cent) where their living situation is unknow. 17 per cent of patients were flagged as having a carer, while 4.8 per cent were flagged as being carers themselves.

Table 8: Living condition flags

Living condition flag	Frequency	Percent of all patients with flag
Patient Lives with Family / Friend / Carer	1,600	33.1
Lives Alone with Regular Support	1,138	23.5
Patient has a Carer	822	17.0
Lives Alone without Regular Support	462	9.5
Patient has no Caring Status	312	6.4
Needs one-to-one Support	310	6.4
Personal Care	250	5.2
Patient is a Carer	230	4.8
Hazardous Living Situation	63	1.3
Lives in Supported Living	11	0.2

20.9 per cent of patients had at least one flag that related to a 'social issue' (see table 9). The most common were 'transport issues' (15.2 per cent of all patients) and 'financial limitations' (5.8 per cent).

Table 9: Social issue flags

Social issue flag	Frequency	Percent of all patients
Transport Issues	738	15.2
Financial limitations	283	5.8
Language or illiteracy	70	1.4
Childcare	16	0.3
Isolated	16	0.3

In terms of health and wellbeing conditions the most common individual flags are shown in Table 10. Hypertension was the most frequent, flagged for over a third of all patients (37.3 per cent). Mobility and unsteadiness issues, were also very common flagged (32.8 per cent, 24.4 per cent), followed by diabetes (21.4 per cent) and arthritis (19.8 per cent).

Table 10: Ten most common flags

Health / wellbeing issue	Frequency	Percent of all patients
Hypertension	1,803	37.3
Mobility	1,588	32.8
Falls/Unsteady on Feet	1,180	24.4
Diabetes	1,037	21.4
Arthritis	960	19.8
Chronic Kidney Disease	716	14.8
Low Confidence	713	14.7
COPD	648	13.4
Dementia	646	13.3
Osteoarthritis	570	11.8

Patient outcomes

6

6.1. Referral outcomes

64.4 per cent (7,203) of all referrals have an associated outcome recorded. Of these, 24.2 per cent (1,740) ended with a transfer to a new contract or service. 61.9 per cent (4,460) of referrals had a 'successful' outcome. Of these, the five most common were (accounting collectively for 74.2 per cent of all successful outcomes):

- 'Completed service successfully no known destination' (30.8 per cent).
- 'Improved financial wellbeing' (20.3 per cent).
- 'Improved independent living' (10.0 per cent).
- 'No longer requires service' (7.5 per cent).
- 'Continuing service sustained by other funding' (5.7 per cent).

13.9 per cent (1,003) referrals had an 'unsuccessful' outcome. An unsuccessful outcome generally refers to a reason why the patient has been unable to start a service, rather than having a negative experience. The five most common types were (accounting for 91.6 of all unsuccessful outcomes):

- 'Patient declined service' (45.0 per cent).
- 'Patient could not be contacted' (25.5 per cent).
- 'Service does not meet the patient's needs' (10.6 per cent).
- 'Patient ill and unable to start service' (6.7 per cent).
- 'Patient in residential care unable to start service' (3.9 per cent).

24.2 per cent (1,740) were listed as 'Contract end transfer to new contract', which indicates that they remain a social prescribing service user.

6.2. Wellbeing outcomes

Patients were asked to fill out a wellbeing questionnaire on their first social prescribing visit and after four months. They were asked to rate their wellbeing on eight different measures on a scale of 1 to 5. Out of 4,840 patients recorded on the social prescribing system, 4,387 have at least one set of wellbeing scores recorded. 2,365 of these had a valid follow-up score. The average scores of both baseline and follow-up scores are shown in Table 11. This table shows that initial scores were lowest for the questions relating to 'managing symptoms', 'feeling positive' and 'lifestyle'.

Baseline scores where a positive follow-up score is available are slightly higher than for all baseline scores. This may suggest that those with better initial wellbeing scores are more likely to engage and stay connected with the social proscribing programme, and hence undertake a telephone follow-up with the VCSA.

For those that do have a follow-up score, the biggest improvements were seen in terms of 'money', which may relate to benefits advice, 'feeling positive' and 'work volunteering and other activities'.

**Table 11: Baseline and follow-up average scores**

Question	All baseline scores	Baselines with a valid follow-up	Valid follow ups	Average score change
Family and Friends	3.3	3.4	3.6	0.1
Feeling Positive	2.7	2.8	3.1	0.4
Lifestyle	2.7	2.8	3.0	0.2
Looking After Yourself	3.0	3.0	3.2	0.1
Managing Symptoms	2.5	2.6	2.8	0.2
Money	3.4	3.4	3.9	0.5
Where You Live	3.6	3.7	3.8	0.2
Work Volunteering and Other Activities	2.3	2.4	2.7	0.3

As with previous reports, we found that those with initially low wellbeing scores were more likely to see notable improvements, while those with the highest initial scores were more likely to see no change or a deterioration.

Caution is needed due to a statistical property known as 'regression to the mean'. This means that very low or high scores can always be expected to be less extreme at a follow up recording, due to natural variation in individual scores. Very low scores have nowhere else to go except up.

Nevertheless, it is also possible that at least some of the additional improvement for those with the lowest initial scores is because their wellbeing challenges are more susceptible to intervention via social prescribing. Further research using control group data, which was not possible for this study, would help to clarify the extent to which this is the case.

Figure 8: Average change in score for each wellbeing category (initial score)
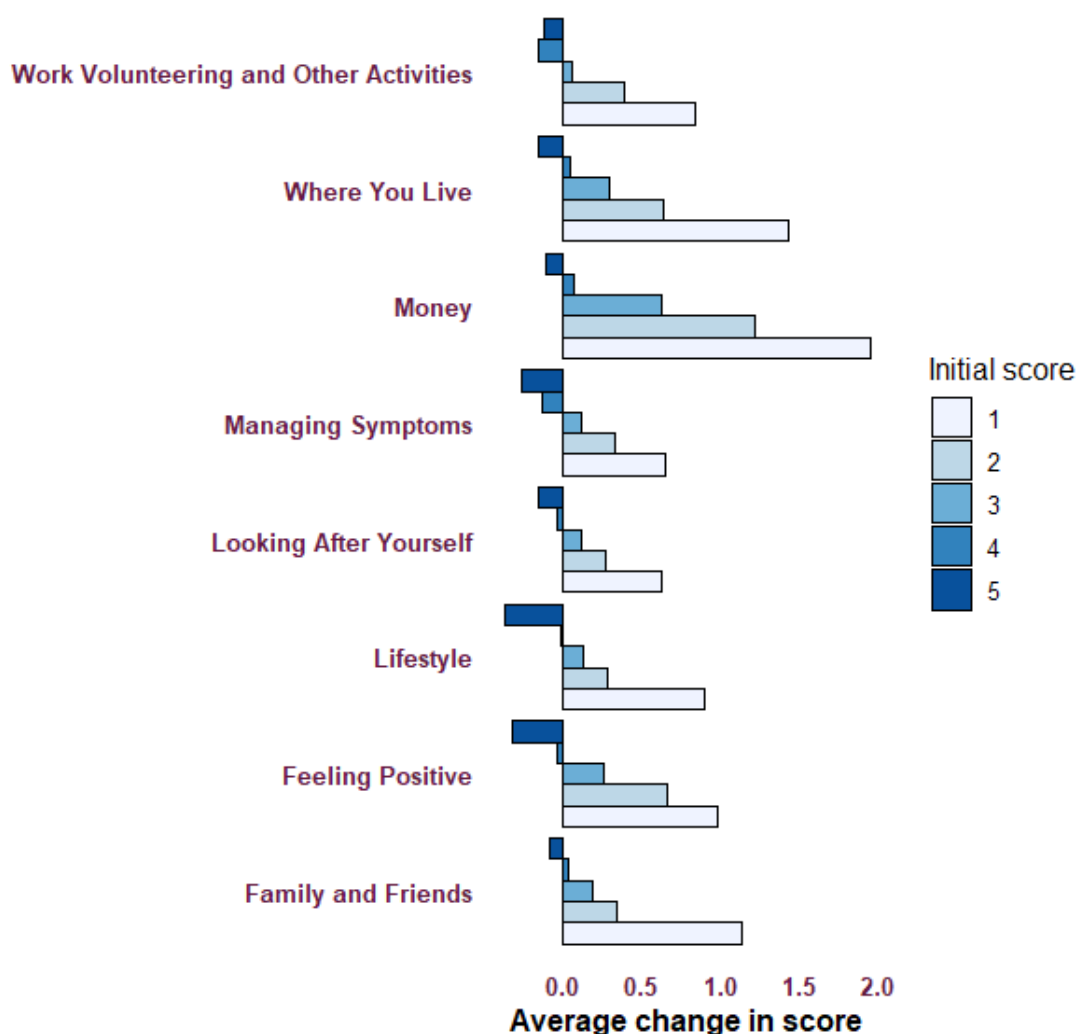
6.3. Hospital admissions

Wherever possible, patients participating in the RSPS were linked to their patient-level, hospital episode data, to assess their use of secondary (i.e. hospital based) care. This data was pseudonymised, which means that the research team were not able to identify any individuals whilst conducting the analysis. This analysis is important from an evaluative perspective, as the social prescribing programme was commissioned, in part, to help reduce the number and cost of secondary care interventions for 'high-use' or 'high-cost' individuals. As part of the referral process, GPs and their multi-disciplinary teams were encouraged to prioritise those patients deemed most at risk of unplanned and potentially unnecessary admissions.

Two outcome measures were explored:

- The number of non-elective continuous inpatient spells
- The number of accident and emergency attendances

6.3.1. In-patient spells

New analysis has been conducted on service users contacted by the social prescribing service for the first time between April 2019 and March 2022. Overall, for 2,365 patients with initial contact visits within this period, the average number of in-patient

spells is 1.24 in the 12 months prior to RSPS contact, and 1.25 in the following 12 months. This is a negligible increase of 0.01 in-patient spells, similar to the overall change of 0.03 previously reported for 2016-2018 (Dayson and Damm, 2020).

These results can be broken down by the year in which the first VCSA assessment occurred and compared to the figures previously reported in Dayson and Damm (2020) for April 2016 to March 2018. Complete data for participants engaged between April 2018 and March 2019 was not available at the time of reporting.

There is not a particularly clear pattern between years, with the average change oscillating around zero. The results for 2020-2021 shows a modest increase in attendance in the 12 months following first contact compared to other years. Notably, however, this will have overlapped significantly with the first year of the COVID-19 pandemic, which may have had a substantial impact.

Table 12: In patient spells before and after RSPS first contact, by year of first visit

		In-patient spells average		
	Number of patients	12 months before	12 months after	Change
2016-2017	758	1.63	1.56	-0.07
2017-2018	972	1.27	1.37	0.10
2018-2019	Unavailable	Unavailable	Unavailable	Unavailable
2019-2020	798	1.27	1.18	-0.09
2020-2021	688	1.05	1.27	0.21
2021-2022	879	1.35	1.30	-0.05

Table 13 breaks the results down by the number of in-patient spells in the 12 months prior to their first RSPS assessment. The results suggest that patients with a higher level of hospital use, prior to their initial RSPS assessment, were more likely to see their use fall in the following 12 months. Caution interpreting these results is necessary, however. Firstly, patients who have died since their initial visit are not included, which may reduce the post 12-month average for high users. Second, as discussed in the previous section, regression to the mean suggests that high users are more likely to see a drop in their number of visits, simply because individuals naturally oscillate around their own average level. The higher an individual starts, the more room there is to see a reduction.

Table 13: In patient spells before and after RSPS first contact, by the number of spells in the previous 12 months

		In-patient spells average		
Spells in 12 months before	Number of patients	12 months before	12 months after	Change
0	1,209	0.0	0.7	0.69
1	548	1.0	1.1	0.12
2	256	2.0	1.4	-0.57
3	138	3.0	1.8	-1.18
4	87	4.0	2.7	-1.32
5+	127	8.7	5.2	-3.50

We also broke the results down by gender and age (Tables 14 and 15). The differences by age largely reflect those seen in Dayson and Damm (2020), with the largest increases in service use seen by the most elderly, though with more variation amongst the lower age groups than seen previously. The differences by gender are so small as to be negligible.

Table 14: In patient spells before and after RSPS first contact, by age

Age	Number of patients	In-patient spells average		Change
		12 months before	12 months after	
21-30	24	1.0	0.9	-0.13
31-40	57	0.4	0.5	0.11
41-50	68	1.3	0.9	-0.40
51-60	188	1.3	1.3	-0.01
61-70	279	1.3	1.3	0.03
71-80	569	1.7	1.4	-0.24
81-90	827	1.1	1.2	0.11
91-100	333	0.9	1.2	0.29
101-110	14	0.3	0.7	0.43

Table 15: In patient spells before and after RSPS first contact, by gender

Gender	Number of patients	In-patient spells average		Change
		12 months before	12 months after	
Female	1,440	1.2	1.2	0.05
Male	924	1.4	1.3	-0.03

6.3.2. *Accident and Emergency (A&E) visits*

As for in-patient spells, the number of visits to accident and emergency does not appear to have changed substantially in the 12 months before or after first contact from RSPS. The average number of A&E visits in the 12 months before first contact was 1.17, and for the 12 months after the average was 1.18, a change of just 0.01.

The results are again broken down by year and compared to those in 2016-2018 in Table 16. 2020-2021 again demonstrated a slightly larger increase than other years, perhaps reflecting the impact of the COVID-19 pandemic, though not to the same degree as for in-patient spells.

Table 16: A & E admissions before and after RSPS first contact

	Number of patients	A&E visits average		
		12 months before	12 months after	Change
2016-2017	758	1.03	1.07	0.04
2017-2018	972	1.04	1.12	0.08
2018-2019	Unavailable	Unavailable	Unavailable	Unavailable
2019-2020	798	1.21	1.22	0.01
2020-2021	688	1.08	1.21	0.13
2021-2022	879	1.20	1.12	-0.08

Table 17 breaks down the results by the number of times patients visited A&E in the 12 months prior to their first RSPS visit. As with in-patient spells, higher initial users see larger falls than those with previously lower levels of attendance. Again, however, without a control group, the extent to which this is explained by regression to the mean cannot be determined.

Table 17: A & E admissions before and after RSPS first contact, by the number of visits in the previous 12 months

A&E visits in 12 months before	Number of patients	12 months before	12 months after	Change
0	1164	0	0.72	0.72
1	573	1	1.04	0.04
2	296	2	1.30	-0.70
3	146	3	1.82	-1.18
4	69	4	2.43	-1.57
5+	117	8	4.57	-2.98

Breaking down the results by gender in Table 19 again shows very little difference in changes to attendance. The results do differ by age, even more clearly than for in-patient spells. Older patients are more likely to see an increase in attendance following an initial visit, while younger patients are more likely to see a reduction. It may be the older patients are already on a trajectory of increasing A&E attendance. Whether social prescribing slows this progression is again something that could be explored in future research using a matched control group.

Table 18: A & E admissions before and after RSPS first contact, by patient age

Age	Number of patients	12 months before	12 months after	Change
21-30	24	3.04	2.79	-0.25
31-40	57	1.02	0.96	-0.05
41-50	68	1.24	0.84	-0.40
51-60	188	1.37	1.29	-0.09
61-70	279	1.15	1.02	-0.14
71-80	569	1.18	1.11	-0.07
81-90	827	1.08	1.22	0.15

91-100	333	1.17	1.26	0.10
101-110	14	0.50	0.93	0.43

Table 19: A & E admissions before and after RSPS first contact, by patient gender

Gender	Number of patients	12 months before	12 months after	Change
Female	1440	1.14	1.20	0.05
Male	924	1.21	1.16	-0.05

6.4. Financial benefits

As highlighted by the data present in 4.3, the most frequent type of social prescribing onward referral is to 'Information advice and benefits', whilst section 6.2 demonstrates that 'Money' is the wellbeing category with the greatest change score. Further insight into the scale and impact of the work the social prescribing service does to promote financial benefits can gleaned by exploring the total value of benefits brought in on behalf of patients following their referral. Table 20 provides annuals figure for each year 2016/17-2021-22. This shows that more than £1 million was brought in for each year data was available and more than £5.8 million in total. On average, this equated to £1,749 per year for each patient supported.

Table 20: Value of benefits brought in for patients following referral

	Number of patients supported to access benefits	Total value of benefits	Average value of benefits per patient referred
2016-2017	721	£1,125,504	£1,561
2017-2018	*Unavailable*	*Unavailable*	*Unavailable*
2018-2019	779	£1,379,708	£1,771
2019-2020	724	£1,257,877	£1,737
2020-2021	576	£1,063,034	£1,846
2021-2022	551	£1,030,464	£1,870
Total	3,348	£5,856,587	£1,749

6.5. Understanding how change happens

The previous sections have highlighted some of the key statistical data about the Rotherham Social Prescribing Services and point to a range of benefits for patients associated with their health and wellbeing. This begs the question how does change happen? What is it about the service that makes these benefits possible? The best way to answer this question is through case examples of social prescribing patients and their journeys with the service.

Case example 1: 'Jenny', female, aged 56

Jenny had been experiencing range of issues which led her GP to believe she would benefit from a referral to social prescribing. Following a recent stroke, she was prescribed blood thinners but was struggling with poor sleep, low energy and poor concentration. She was also feeling socially isolated and struggling with low mood and depressive symptoms. Jenny told the VCSA that was unhappy where she lived and

wanted to be nearer her family. She was also having some problems with her benefits: her only source of income was Employment Support Allowance (ESA) and a previous application for Personal Independence Payments (PIP) had been turned down.

Following a full holistic assessment with a VCSA a support plan for jenny was agreed that involved the following referrals:

- Befriending and enabling to support her to access local community groups.

- Benefits check and advocacy to help her claim all the benefits she was entitled to and to challenge PIP decision and received support with rehousing.

- Counselling to support her mental health.

- Home-based digital inclusion support to build skills and confidence to use the internet and associated technologies.

A number of positive outcomes have been reported following Jenny's social prescribing referral:

Financial wellbeing: following the PIP challenge, she was awarded enhanced Daily Living and Mobility entitlements from 2022 until 2029 meaning she was more than £8,000 per year better off.

Social isolation: she has moved house to be nearer her family, has formed new friendships following participation in social and peer support groups, and regularly attends a Functional Fitness Stroke Rehabilitation group.

Independence: she now has the confidence to use the Door-to-Door transport service and Shopper Bus service, meaning she can attend community groups and activities without support.

Digital inclusion: she has access to a tablet computer (loan) and is able to do internet shopping and online banking.

Health: she reports improved sleep and concentration and feels more "normal" following her stroke and memory loss.

Personal wellbeing: she has more confidence and motivation, and a sense of pride in what she has been able to achieve.

Case example 2: 'Margaret', female, aged 85

Maragret was referred by her GP to a VCSA who arranged a home visit where they identified that Margaret was living with a range of issues. Her house was cluttered and untidy and no longer adequate her needs as she was struggling to climb the stairs due to worsening mobility. Margaret had become frail which was limiting her mobility and led her to spend lots of time sitting down with little exercise of her leg muscles. This situation had led to Margaret becoming socially isolated: she was not getting out, had lost partner and her family had moved away. She'd brought a laptop to help with this but was anxious about not being able to use it properly.

Following an assessment by a VCSA a support plan was agreed to address the issues identified. It included the following support:

- Cleaning services provided via Age UK.
- Enabling support from Live Inclusive who supported her to join a social group at the local community centre and to book community transport to get there and back independently.

- The VCSA contacted the Housing Department at the council to report request more suitable accommodation and have some necessary repairs completed in the meantime
- Purchase of a mobility scooter and participation in a local gentle exercise class to improve her strength, with the aim of reducing the likelihood of falls.
- Referral to a digital skills support service offering home visits.
- Signposting to a telephone befriending service.

A number of positive outcomes have been reported following Margaret's social prescribing referral:

Financial wellbeing: she was supported by Age UK to claim benefits she had not claimed and was entitled which enabled her to pay for a cleaning service.

Personal wellbeing: she says she feel much better on a day-to-day basis knowing she is not, in her words 'under pressure' to clean, when she feels unable to. She is, however, more motivated, saying she cleans a little more than she used to and feels good about this.

Social isolation: she now attends a community flower arranging class in a local community centre and enjoys calls from the telephone befriending service once a month.

Independence: she now arranges her own transport and attends the weekly social group independently. She says it is like having a new lease of life and has decided she does not need a mobility scooter yet and is now attending a community gentle exercise class.

Digital inclusion: she is now able to use her laptop and is online. She says she feels more connected to the outside world and has learned how to order her shopping online.

Sheffield Hallam University

Copyright and re-use policy