Sheffield Hallam University | Centre for Regional Economic and Social Research

The Rotherham Social Prescribing Service for People with Long-Term Health Conditions

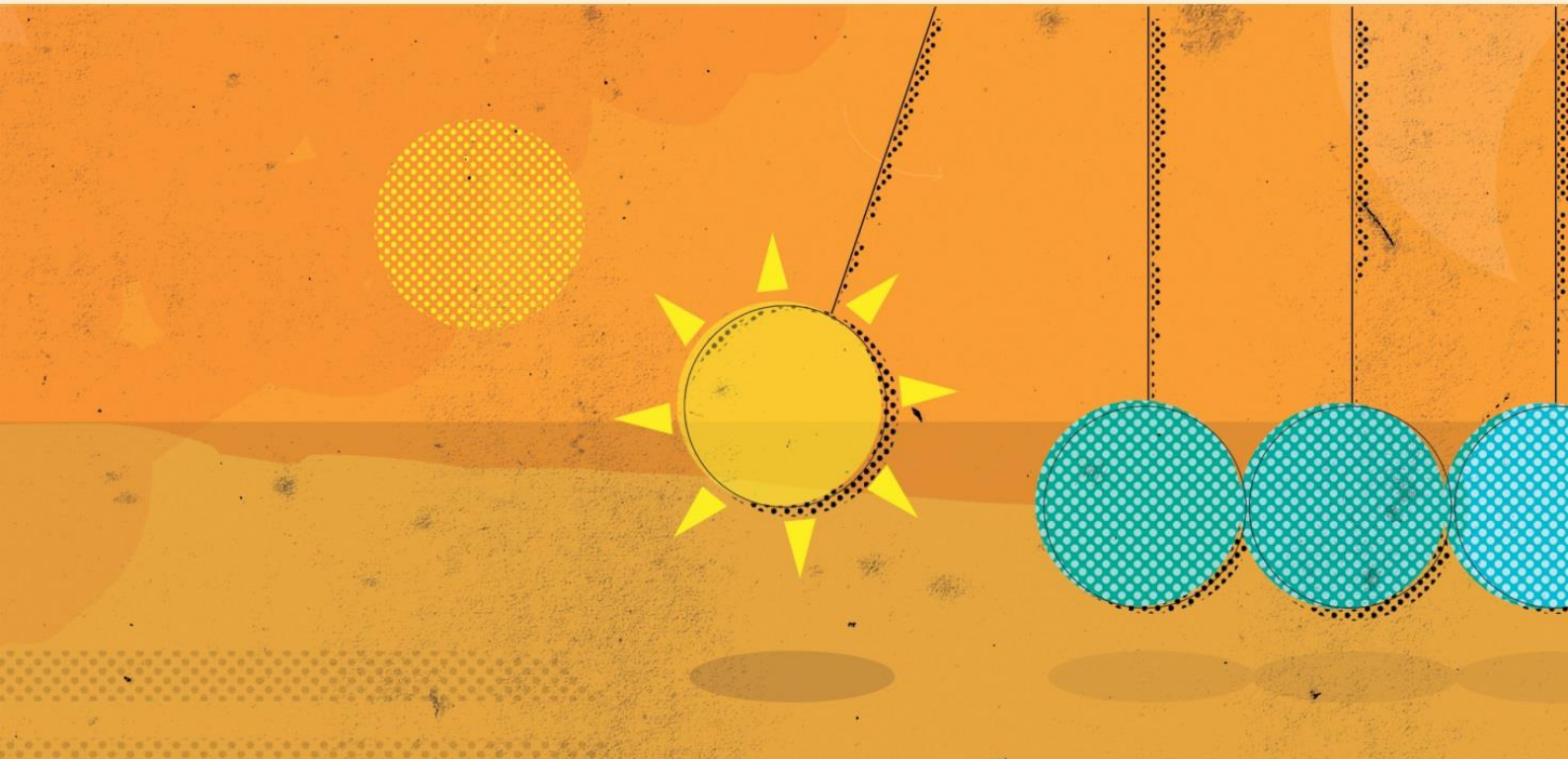
Annual Evaluation Report

January 2016

Rotherham Social Prescribing Service
Health in your hands

VoluntaryAction Rotherham

NHS
Rotherham Clinical Commissioning Group



The Rotherham Social Prescribing Service for People with Long-Term Health Conditions

Annual Evaluation Report

Author(s):

Chris Dayson

Nadia Bashir

Ellen Bennett

Elizabeth Sanderson

January 2016

Acknowledgements

The Evaluation of the Rotherham Social Prescribing Service is being undertaken by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University, on behalf of Voluntary Action Rotherham (VAR) and funded by NHS Rotherham Clinical Commissioning Group. The Evaluation Team would like to thank representatives of the public, voluntary and community sectors who gave up their time to contribute to the study. We are particularly grateful to Linda Jarrold and Barry Knowles at VAR for their on-going support for the evaluation, and to Alex Henderson-Dunk and colleagues at the South and West Yorkshire and Bassetlaw NHS Commissioning Support Unit for the provision of the NHS data referred to in this report.

Contact information

For CRESR

Name: Chris Dayson
Research Fellow

Address: Unit 10 Science Park
City Campus
Howard Street
Sheffield
S1 1WB

Tel: 0114 2253539

Email: c.dayson@shu.ac.uk

For VAR

Name: Linda Jarrold
Adult Health and Social Care Development Officer (VCS)

Address: Voluntary Action Rotherham
The Spectrum
Coke Hill
Rotherham
S60 2HX

Tel: 01709 834449

Email: linda.jarrold@varotherham.org.uk

Contents

Executive Summary

Introduction

Social prescribing is a catch-all term for non-medical services that aim to prevent worsening health for people with long-term health conditions. In recent years locality-based social prescribing services have increasingly been developed by health and social care commissioners to provide a mechanism for linking patients in primary care with sources of social, therapeutic and practical support in the voluntary and community sector. Social prescribing is being promoted by the Department of Health and NHS England as a vital component in the transformation and integration of health and social care.

In Rotherham the Social Prescribing Service is delivered by Voluntary Action Rotherham (VAR) in partnership with more than 20 local voluntary and community organisations (VCOs). It aims to increase the capacity of GPs to meet the non-clinical needs of patients with complex long-term conditions (LTCs).The Service was first commissioned as a two-year pilot Pilot in 2012. In 2014-15 it was re-commissioned for a further year with an additional 3 years of service provision contracted in April 2015 and funded through the Better Care Fund. At its core a team of Voluntary and Community Sector Advisors (VCSAs) provide a single gateway to voluntary and community support for GPs and Service users. They receive referrals from GPs of eligible patients and carers and assess their support needs before referring on to appropriate VCS services. The Service also administers a grant funding pot through which a 'menu' of VCS activities to meet the needs of Service users is commissioned. The service covers the whole of the borough of Rotherham and is one of the largest of its kind, as the majority of social prescribing activity in the UK has had a much smaller geographic focus and has not provided grant funding for additional services.

This annual evaluation report provides an updated assessment of the social and economic impact of the Rotherham Social Prescribing Service between September 2012 and March 2015.

Impact on the demand for urgent hospital care

Using patient-level Hospital Episode Statistics (HES) the evaluation measured Social Prescribing Service Users' demand for unplanned and urgent hospital care, comparing non-elective inpatient admissions and Accident and Emergency attendances for the 12 months prior to and following their referral to Social Prescribing. The analysis identified an overall trend that points to reductions in Service users' demand for urgent care interventions after they had been referred to Social Prescribing:

- non-elective inpatient episodes reduced by seven per cent
- non-elective inpatient spells reduced by 11 per cent
- Accident and Emergency attendances reduced by 17 per cent.

When Service users aged over 80 are excluded from the analysis the changes are more marked:

- non-elective inpatient episodes for Service users aged under 80 reduced by 19 per cent
- non-elective inpatient spells for Service users aged under 80 reduced by 20 per cent
- Accident and Emergency attendances for Service users aged under 80 reduced by 23 per cent.

Social impact

People with long-term conditions who were referred to the Social Prescribing Service experienced improvements in their well-being and made progress towards better self-management of their condition. Analysis of well-being outcome data showed that, after 3-4 months, 82 per cent of these Service users, regardless of age or gender, had experienced positive change in at least one outcome area. Importantly, when the results were broken down by category they showed that progress was made against each outcome measure and that a majority of low-scoring patients made progress.

These findings were reinforced by case study interviews with a number of Social Prescribing Service users and providers who identified a range of well-being outcomes as a result of being referred to the Social Prescribing Service. They are particularly effective at reducing social isolation and loneliness for people with long-term conditions, enabling them to become more independent and engaged in their community.

Economic and social benefits

The economic benefits to commissioners have been estimated based on the NHS costs avoided that are associated with reductions in the demand for urgent hospital care:

- the estimated total NHS costs avoided between 2012-15 were more than half a million pounds: an initial return on investment of 43 pence for each pound (£1) invested
- if the benefits identified are fully sustained over a longer period
  - the costs of delivering the service for a year would be recouped about two and a half years
  - the costs avoided after five years could be as high as £1.1 million: a return on investment of £1.98 for each pound (£1) invested
  - if the benefits are sustained but drop-off at a rate of 20 per cent each year they could lead to total costs avoided of £0.68 million: a return on investment of £1.22 for each pound (£1) invested.
  - if the benefits are sustained but drop-off at a rate of 33 per cent each year they could lead to total cost reductions of £0.46 million: a return on investment of £0.83 for each pound (£1) invested.

The value of Service user's well-being outcomes were estimated using financial proxies and techniques associated with social return on investment (SROI) analysis. The estimated value of these benefits was between £0.57 million and £0.62 million in the first year following engagement with Social Prescribing: greater than the costs of delivering the service.

Social Prescribing Service users who engage fully with VCS provision experience more change than others

There is growing evidence from the evaluation that Social Prescribing has a greater effect for people who are able to engage fully with the Service, in particular those who continue to engage with the VCS beyond their initial 'social prescription'. Service users who completed their initial referral activity or activities were more likely to see a reduction in their use of urgent and emergency care, more likely to experience improvements in their well-being, and represent a much larger per-Service user cost-benefit than those who did not engage as fully. Within this group the benefits were particularly pronounced for Service users who completed their referral activity and continued to engage with the voluntary and community sector once this initial activity was complete. This highlights the importance of ensuring that the types of people referred to Social Prescribing are those who are able to engage fully in order to experience the greatest benefit from the types of service available.

1 Introduction

1.1. What is social prescribing?

Social prescribing is a catch-all term for non-medical services and referral pathways developed with the aim of preventing worsening health for people with long-term health conditions and reducing the number and intensity of costly interventions in urgent or specialist care. In recent years a number of locality-based social prescribing services have been developed by health and social care commissioners to provide a mechanism for General Practitioners and other primary care services to link patients with sources of social, therapeutic and practical support in their locality, provided primarily by voluntary and community sector organisations. These social prescribing services have been developed in the context of a policy environment in which greater emphasis is placed on integrated preventative interventions for people from marginalised and disadvantaged groups[1] alongside a pressure to reduce public sector budgets and implement market-based approaches to delivery. The Department of Health[2] has advocated social prescriptions for almost 10 years whilst more recently NHS England[3] has promoted non-clinical interventions from the voluntary and community sector as a way of making general practice more sustainable.

1.2. Social prescribing in Rotherham

The Rotherham Social Prescribing Service is commissioned by NHS Rotherham Clinical Commissioning Group (CCG) as part of a wider approach to GP-led Integrated Case Management. Delivered by Voluntary Action Rotherham (VAR) in partnership with more than 20 local voluntary and community organisations (VCOs), it 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.[4] Specific support for the carers of case-managed patients is also provided. At its core, Social Prescribing provides 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

[1] HM Government (2010) *Healthy Lives, Healthy People: Our strategy for public health in England*. London: Department of Health.
[2] HM Government (2006) *Our Health, our care, our say: a new direction for community services.* London: Department of Health.
[3] NHS (2014) *Improving general practice: a call to action (Phase one report).* London: NHS England.
[4] A risk stratification tool is used to identify the five per cent most intensive users of services: these patients and their carers are eligible for case management and can access social prescribing.

- 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 Social Prescribing.

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 3 years of service provision commissioned in April 2015. In addition, a 'sister' social prescribing service for people with mental health conditions is also being piloted throughout 2015-16.

The annual funding agreement covers the core cost of delivering the Service alongside a grant funding pot for a 'menu' of VCS activities that have been specifically developed to meet the needs of Service users. A core team consisting of a Project Manager and five Voluntary and Community Sector Advisors (VCSAs) is employed by VAR. The Project Manager oversees the day-to-day running of the Service, including management of the grant programme, and acting as a liaison between VCS providers and wider NHS structures. The VCSA role provides the link between the Service and the multidisciplinary ICMTs. They receive referrals from GP practices of eligible patients and carers and make an assessment of their support needs before referring them on to appropriate VCS services. The assessment typically takes place during a home visit 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.

The Service covers the whole of the borough of Rotherham. As such it is one of the largest of its kind, as the majority of social prescribing activity in the UK has had a much smaller geographic focus and has not provided grant funding for additional services. The Service has also received national recognition: in March 2014 it received the *'Excellence in Individual Participation Commissioner'* award at *NHS England's Excellence in Participation Awards 2014*. In addition, it has been influential in the development of NHS policy at a national level, including as part of the NHS *'Improving general practice - a call to action'* initiative, which aims to support action with the potential to transform services in local communities and stimulate debate about how general practice can be supported to improve outcomes and tackle inequalities.

1.3. About the evaluation

Since its inception as a pilot in 2012, the Rotherham Social Prescribing Service has been the subject of a rigorous evaluation by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University. An interim pilot evaluation report, [5] published in December 2013, identified emerging lessons from the evaluation and provided a series of recommendations for stakeholders and commissioners going forward. A final pilot evaluation report,[6] published in September 2014 provided more in-depth understandings of its social and economic impacts, with more detailed analysis of cost-benefits and return on investment, including assessing the potential cost savings and efficiencies to the NHS.

[5] http://www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/rotherham-social-prescribing-final.pdf
[6] http://www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham.pdf

1.4. About this report

This annual evaluation report builds on the final pilot evaluation report to provide an updated assessment of the social and economic impact of the Rotherham Social Prescribing Service between September 2012 and March 2015. It focusses on the main element of the service that supports people with long-term health conditions,[7] drawing on a variety of data sources:

- analysis of client management and monitoring data collected by VAR
- analysis of hospital episodes data for a cohort of Service users of the service between 2012 and 2014
- case studies involving Service users.

The report is divided into the following chapters:

- Chapter 2 provides an overview of the activities and outputs of the Service
- Chapter 3 provides analysis of the impact of the Service on the demand for hospital care
- Chapter 4 provides analysis of the social impact of the Service
- Chapter 5 provides analysis of the economic and social cost-benefits of the Service
- Chapter 6 is the conclusion and outlines the business case for continuing Social Prescribing in Rotherham
- Appendix 1 provides three detailed case studies of services provided to Social Prescribing Service users
- Appendix 2 provides a summary of the additional grant-funded services available to Social Prescribing Service users.

[7] An evaluation of the Social Prescribing Service for people with mental health conditions is also being undertaken, the findings of which will be published during 2016.

2 Social Prescribing activities and outputs

This chapter provides an overview of the activities and outputs of the Rotherham Social Prescribing Service drawing on the comprehensive programme and client monitoring data collected by the VAR project team. It begins with an overview of the outputs and activities delivered between 2012-13 and 2014-15 before discussing in more detail the types of voluntary and community sector services provided and the range of referrals in to and out of the Service.

2.1. Commissioning from voluntary and community sector providers

The Service has provided grants to local VCS organisations across a number of phases:

- Autumn 2012: 10 voluntary and community organisations (VCOs) were commissioned to deliver an initial suite of pilot services. Although some of these services began receiving referrals towards the end of 2012 (November/December) the majority did not commence until January 2013 onwards.
- Spring 2013: a further 13 VCOs were commissioned to deliver pilot services. These services began receiving referrals from June 2013 onwards.
- April 2014: 27 VCOs were commissioned to deliver a revised menu of 32 services under the new Better Care Fund contract.
- April 2015: the menu of services was updated, with 17 VCOs commissioned to deliver 20 different services.

The range of organisations providing grant-funded Social Prescribing services has remained relatively consistent. Of the 23 VCOs in receipt of funding during the pilot phase 12 received funding in 2014-15. An overview of organisations funded through the Service is provided in Appendix 2.

2.2. Social prescribing referrals

The section provides an overview of social prescribing referral patterns between 2012-13 and 2014-15. It covers both referrals-in to the Service (i.e. by GPs and ICMTs to VCSAs) and referrals-out (i.e. by VCSAs to funded VCS services and wider provision).

Referrals-in to Social Prescribing

Between September 2012 and March 2015 the Service received referrals from 35(out of 36) GP practices in Rotherham as part of the Case Management Pilot. Overall, 1,991 Service users were actively engaged by the Social Prescribing Service.[8] An annual breakdown of this engagement is provided in Table 2.1 with a breakdown of referrals by key characteristics provided in Table 2.2 and discussed in the sections that follow.

Table 2.1: Annual breakdown of GP referrals-in engaged by the Rotherham Social Prescribing Service

	No. of Users Engaged by SPS			
	2012-13	*2013-14*	*2014-15*	*Total*
No of referrals-in engaged	218	779	994	1,991

Table 2.2: Annual breakdown of GP referrals-in engaged by the Rotherham Social Prescribing Service by key characteristics

	No. of Users Engaged by SPS			
	2012-13	*2013-14*	*2014-15*	*Total*
Age:				
Under 50	9	39	66	114
50-59	19	64	68	151
60-69	23	123	121	267
70-79	61	224	298	583
80-89	86	260	338	684
90 and over	16	61	97	174
Gender:				
Male	80	298	381	759
Female	138	481	613	1,232
Ethnicity:				
White British	205	685	954	1,844
Asian	8	33	24	65
Black	0	1	2	3
White Other	5	6	3	14
Unknown	0	54	11	65

[8] This defined for the purposes of evaluation as being assessed by a VCSA **and** being referred or signposted to grant-funded VCS services, other VCS services or non-VCS services. Service users who died following engagement have also been excluded from this and subsequent analysis as it has not been possible to track their outcomes for the full period.

Age

The majority of patients referred to the Service were elderly:

- six per cent were aged under 50
- eight per cent were aged 50-59
- 14 per cent were aged 60-69
- 30 per cent were aged 70-79
- 35 per cent were aged 80-89
- nine per cent were aged 90 or over.

Gender

Females (62 per cent) were more likely to be referred to the Service than males (38 per cent).

Ethnicity

A large majority of referred patients were from a White ethnic background (93 per cent) with four per cent from other ethnic backgrounds.[9]

Referrals-out

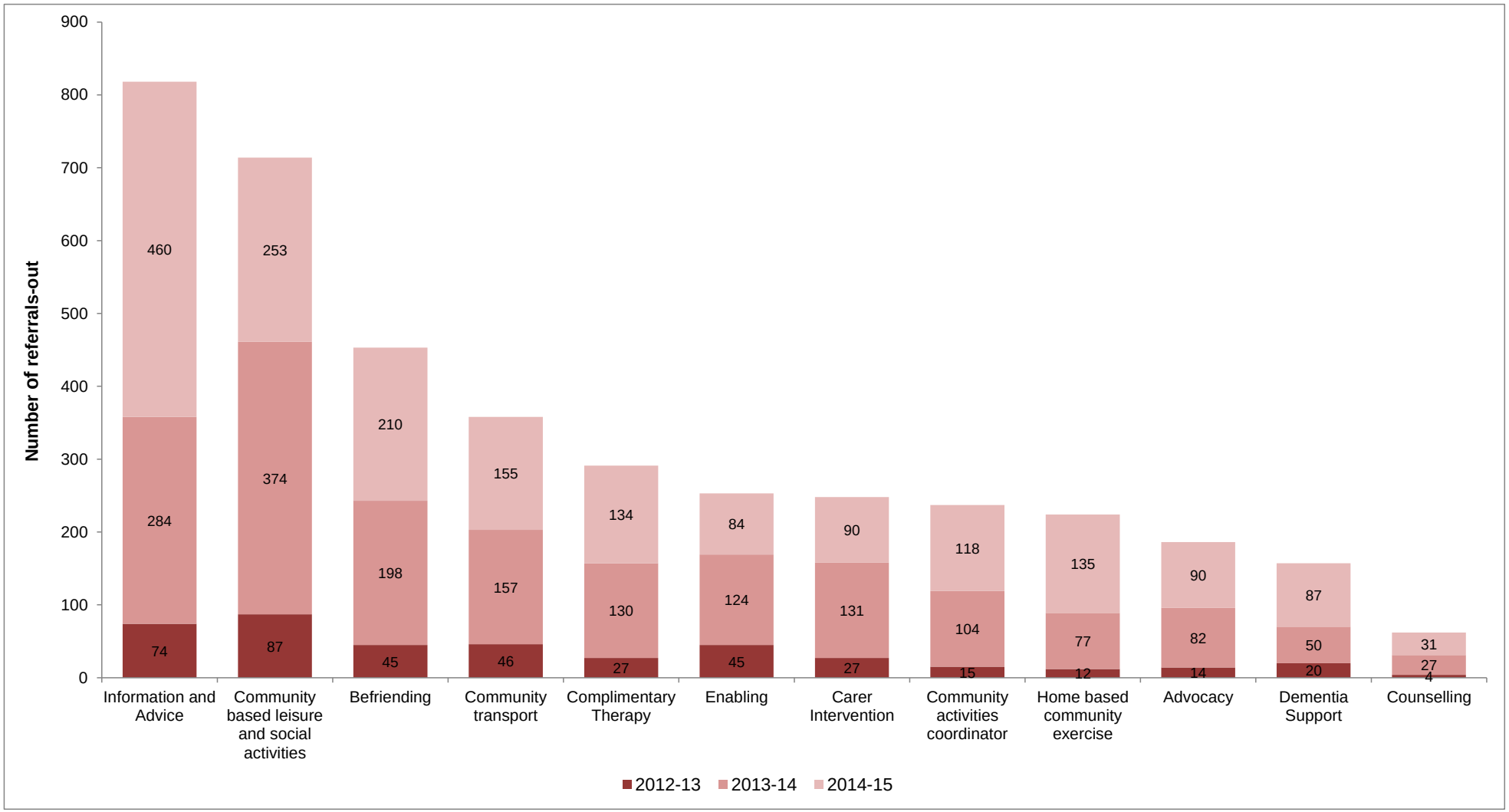
Funded VCS services

Over the course of 2012-2015 there were 4,702 onward referrals of 722 individual users (many had more than one onward referral) to funded VCS services. Figure 2.1 provides an overview of referrals-out to the VCS by service type.

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

[9] Three per cent of SPS users' ethnicity was not stated.

Figure 2.1: Overview of referrals-out to funded VCS services by service type (2012-13 - 2014-15)



Multiple referrals to funded provision are also a notable feature of the support Service users receive through Social Prescribing. Three-fifths of all (61 per cent) users referred-out to grant-funded provision through the Service were referred to more than one service. Of these, 28 per cent received two referrals-out, 18 per cent received three, 10 per cent received four, and 6 per cent received five or more.

Wider VCS provision

In addition to referrals to VCS services in direct receipt of funding through the Social Prescribing Service, 38 per cent of Service users were referred to the wider pool of VCS provision available in the borough. This included other services available from existing Social Prescribing providers such as Age UK (for example gardening and cleaning services) as well as services available from other VCS organisations such as Headway and Stayput.

This highlights how Social Prescribing continues to act as a gateway to a wider pool of VCS provision, and the added value this brings to commissioners, GPs and Service users, who would have otherwise needed to find out about these services themselves, or have simply been unable to gain access to these types of services.

Statutory provision

VCSAs also make referrals-out to statutory sector services with 40 per cent of Service users referred to additional statutory provision. The most common of these were RMBC OT Assessment and Intermediate Care and the Fire Brigade for fire safety checks, but referrals were also made to NHS services such as Breathing Space and community-level services such as falls prevention classes and community alarms. Although it cannot be said for certain that these Service users would not have found out about these services through other means, in many cases it will have ensured that they were able to access much needed support sooner rather than later.

.

3

Impact on the demand for hospital care

This chapter presents analysis exploring the impact of the Rotherham Social Prescribing Service on demand for hospital-based health interventions. It draws on patient-level Hospital Episode Statistics (HES) provided by the NHS to map over time the use of hospital resources by patients referred to the Social Prescribing Service since its inception. Three aspects of hospital episodes are considered: non-elective inpatient episodes and spells; the length of stay for non-elective inpatient admissions; and the number of Accident and Emergency attendances.

3.1. Methodology

Data sources and variables

The analysis presented in this chapter is based on pseudonymised patient-level hospital episode data for Social Prescribing Service users provided by the NHS Data Management and Integration Centre (DMIC). Data linkage was made using the NHS numbers of Social Prescribing Service users provided by Voluntary Action Rotherham. Following exploratory analysis of all the data provided a series of outcome variables were created to provide the basis of the headline analysis presented in this report:

- The number of non-elective inpatient episodes (FCEs)[10] in the 12 months before and after the first contact with Social Prescribing.
- The number of non-elective continuous inpatient spells[11] in the 12 months before and after the first contact with Social Prescribing.
- The number of bed days as a non-elective inpatient in the 12 months before and after the first contact with Social Prescribing.
- The number of Accident and Emergency attendances in the 12 months before and after the first contact with Social Prescribing.

[10] A Consultant Episode (Hospital Provider) is the time a patient spends in the continuous care of **one consultant** using Hospital Site or Care Home bed(s) of one Health Care Provider.
[11] A Hospital Provider Spell is the total continuous stay of a patient using a Hospital Bed on premises controlled by a Health Care Provider during which medical care is the responsibility of **one or more** consultants.

It is important to note that a number of improvements have been made to the methodology that means the findings cannot be directly compared to previous reports. In particular, the sample now includes Service users for whom no urgent care activity was recording during the 12 months before and after referral. This has the effect of lowering the mean number of episodes and the number of Service users for who change is possible. In addition, the previous analysis only included non-elective inpatient episodes (FECs) and not spells, whilst outpatient attendances have not been included in this analysis as the data available are only partial.[12]

Sampling

Analysis focussed on users that were referred to the Social Prescribing Service in 2012-13 and 2013-14 (i.e. September 2012 - Mar 2014) who engaged with the Service in a substantive way: this means being referred-out to grant-funded services, a wider VCS service, or a statutory service by a VCSA; or being signposted to one of these services. For these Service users sufficient time had elapsed post-referral to observe changes in their utilisation of hospital services over a 12-month period. The sample included 199 Service users whose first contact with the Service was in 2012-13 and 740 whose first contact was in 2013-14. The full sample therefore includes 939 Social Prescribing Service users who engaged substantively during this period.

Analysis

The analysis measured the change in the four hospital resource use measures comparing the 12 months before engagement with Social Prescribing with the 12 months afterward. Sub-category analysis was also undertaken according to type of referral-out, referral outcome, Service user gender and age, and the types of grant-funded referral received. A Wilcoxon Rank Signed Test was undertaken to test for statistical significance.

3.2. Summary of findings

An overview of the analysis undertaken is presented in Tables 3.1-3.4 and the main findings are discussed in the section that follows. All findings discussed are statistically significant unless otherwise stated.

Overall change

Across the full sample of Service users there was consistent pattern:

- The average number of non-elective inpatient episodes changed from 1.25 in the 12-month period before referral to Social Prescribing to 1.16 in the 12 months following referral: an overall reduction of seven per cent (0.09).
- The average number of non-elective inpatient spells changed from 1.02 in the 12-month period before referral to Social Prescribing to 0.90 in the 12 months following referral: an overall reduction of 11 per cent (0.11).
- The average number of non-elective inpatient bed days changed from 6.77 in the 12-month period before referral to Social Prescribing to 8.66 in the 12 months following referral: an overall increase of 28 per cent (1.89). However, this change was **not statistically significant.**[13]

[12] The data only include the first appointment for a particular condition. This means ongoing conditions are not included and the effect on these cannot be measured.
[13] This measure appears to be adversely affected by high levels of variance within in sample. As such no firm conclusions should be drawn from this particular measure.

- The average number of Accident and Emergency attendances changed from 1.29 in the 12-month period before referral to Social Prescribing to 1.06 in the 12 months following referral: an overall reduction of 17 per cent (0.22).

Table 3.1: Change in the average number of non-elective inpatient episodes (FCEs)

	Base	Average (mean) number of non-elective inpatient episodes (FCEs)			
		12m before	*12m after*	*Change*	*% change*
All Service users	939	1.25	1.16	-0.09	-7%
Referrals-out:					
Referred-out to any service	869	1.28	1.17	-0.11	-9%
Referred-out to a grant-funded service	722	1.23	1.18	-0.05	-4%
Referred-out to any type of VCS service	810	1.27	1.17	-0.09	-7%
Referred-out to non-VCS services only	59	1.47	1.08	-0.39	-26%
Signposted-out only	70	0.80	1.06	0.26	32%
Referral outcome:					
Service user completed referral activity	555	1.25	1.10	-0.15	-12%
Service user continued to access VCS services when the initial service ended	73	0.97	0.47	-0.51	-52%
Gender:					
Male	357	1.44	1.27	-0.17	-12%
Female	582	1.13	1.09	-0.03	-3%
Age:					
Under 80 only	513	1.49	1.20	-0.28	-19%
Under 50	42	2.21	1.57	-0.64	-29%
50-59	76	1.50	1.28	-0.22	-15%
60-69	134	1.57	1.35	-0.22	-14%
70-79	261	1.32	1.05	-0.27	-21%
80-89	329	0.96	1.08	0.12	13%
90 or over	85	0.80	1.26	0.46	57%
Support category:					
Information and advice	331	1.34	1.22	-0.13	-9%
Enabling	159	1.52	1.63	0.11	7%
Community Activities Co-ordinator	114	1.22	1.22	0.00	0%
Community leisure and social activities	435	1.32	1.14	-0.18	-14%
Befriending	217	1.14	1.39	0.25	22%
Counselling	28	1.00	0.71	-0.29	-29%
Transport	192	1.31	1.29	-0.02	-1%
Exercise in the home/community	78	1.28	1.45	0.17	13%
Carer intervention	147	1.27	1.32	0.05	4%
Complementary therapy	145	0.99	1.01	0.01	1%
Dementia support	65	0.78	0.98	0.20	25%
Advocacy	86	1.70	1.45	-0.24	-14%

Table 3.2: Change in the average number of non-elective inpatient spells

	Base	Average (mean) number of non-elective continuous inpatient spells			
		12m before	*12m after*	*Change*	*% Change*
All Service users	939	1.02	0.90	-0.11	-11%
Referrals-out:					
Referred-out to any service	869	1.04	0.91	-0.13	-13%
Referred-out to a grant-funded service	722	1.00	0.92	-0.09	-9%
Referred-out to any type of VCS service	810	1.03	0.91	-0.12	-12%
Referred-out to non-VCS services only	59	1.17	0.90	-0.27	-23%
Signposted-out only	70	0.70	0.83	0.13	18%
Referral outcome:					
Service user completed referral activity	555	1.02	0.87	-0.15	-14%
Service user continued to access VCS services when the initial service ended	73	0.78	0.38	-0.40	-51%
Gender:					
Male	357	1.16	0.99	-0.17	-15%
Female	582	0.93	0.85	-0.08	-8%
Age:					
Under 80 only	513	1.19	0.95	-0.23	-20%
Under 50	42	1.69	1.21	-0.48	-28%
50-59	76	1.26	1.03	-0.24	-19%
60-69	134	1.23	1.04	-0.19	-15%
70-79	261	1.06	0.84	-0.21	-20%
80-89	329	0.81	0.81	-0.01	-1%
90 or over	85	0.69	1.02	0.33	47%
Support category:					
Information and advice	331	1.10	0.97	-0.13	-12%
Enabling	159	1.23	1.24	0.01	1%
Community Activities Co-ordinator	114	0.99	0.93	-0.06	-6%
Community leisure and social activities	435	1.03	0.91	-0.13	-12%
Befriending	217	0.98	1.05	0.07	8%
Counselling	28	0.79	0.61	-0.18	-23%
Transport	192	1.06	1.01	-0.05	-4%
Exercise in the home/community	78	1.06	1.23	0.17	16%
Carer intervention	147	1.04	1.06	0.02	2%
Complementary therapy	145	0.79	0.74	-0.05	-6%
Dementia support	65	0.71	0.78	0.08	11%
Advocacy	86	1.44	1.24	-0.20	-14%

Table 3.3: Change in the average number of non-elective bed days

	Base	Average (mean) number of non-elective bed days			
		12m before	*12m after*	*Change*	*% Change*
All Service users	939	6.77	8.66	1.89	28%
Referrals-out:					
Referred-out to any service	869	6.98	8.68	1.70	24%
Referred-out to a grant-funded service	722	7.14	8.98	1.84	26%
Referred-out to any type of VCS service	810	7.01	8.81	1.80	26%
Referred-out to non-VCS services only	59	6.58	6.83	0.25	4%
Signposted-out only	70	4.23	8.50	4.27	101%
Referral outcome:					
Service user completed referral activity	555	6.77	8.89	2.11	31%
Service user continued to access VCS services when the initial service ended	73	4.22	2.41	-1.81	-43%
Gender:					
Male	357	7.89	8.61	0.71	9%
Female	582	6.09	8.70	2.61	43%
Age:					
Under 80 only	513	7.43	7.72	0.28	4%
Under 50	42	8.64	6.43	-2.21	-26%
50-59	76	5.96	5.38	-0.58	-10%
60-69	134	8.91	9.07	0.16	2%
70-79	261	6.91	7.91	1.00	14%
80-89	329	5.98	9.02	3.05	51%
90 or over	85	4.81	13.36	8.55	178%
Support category:					
Information and advice	331	6.31	9.25	2.94	47%
Enabling	159	8.88	11.61	2.73	31%
Community Activities Co-ordinator	114	7.65	11.09	3.44	45%
Community leisure and social activities	435	6.82	8.40	1.58	23%
Befriending	217	7.39	12.47	5.08	69%
Counselling	28	5.89	4.68	-1.21	-21%
Transport	192	6.42	9.86	3.44	54%
Exercise in the home/community	78	6.00	7.92	1.92	32%
Carer intervention	147	8.05	10.27	2.21	27%
Complementary therapy	145	6.13	8.83	2.70	44%
Dementia support	65	3.49	9.06	5.57	159%
Advocacy	86	9.72	9.23	-0.49	-5%

Table 3.4: Change in the average number of Accident and Emergency attendances

	Base	Average (mean) number of Accident and Emergency attendances			
		12m before	*12m after*	*Change*	*% Change*
All Service users	939	1.29	1.06	-0.22	-17%
Referrals-out:					
Referred-out to any service	869	1.32	1.08	-0.25	-19%
Referred-out to a grant-funded service	722	1.35	1.12	-0.23	-17%
Referred-out to any type of VCS service	810	1.35	1.11	-0.24	-18%
Referred-out to non-VCS services only	59	0.90	0.61	-0.29	-32%
Signposted-out only	70	0.83	0.87	0.04	5%
Referral outcome:					
Service user completed referral activity	555	1.37	1.03	-0.34	-25%
Service user continued to access VCS services when the initial service ended	73	1.03	0.67	-0.36	-35%
Gender:					
Male	357	1.38	1.16	-0.22	-16%
Female	582	1.23	1.00	-0.23	-18%
Age:					
Under 80 only	513	1.46	1.12	-0.34	-23%
Under 50	42	2.90	1.86	-1.05	-36%
50-59	76	1.76	1.39	-0.37	-21%
60-69	134	1.55	1.13	-0.43	-27%
70-79	261	1.09	0.92	-0.17	-15%
80-89	329	1.02	0.93	-0.09	-9%
90 or over	85	1.04	1.09	0.06	6%
Support category:					
Information and advice	331	1.32	1.08	-0.24	-19%
Enabling	159	1.72	1.64	-0.08	-5%
Community Activities Co-ordinator	114	1.19	1.11	-0.08	-7%
Community leisure and social activities	435	1.33	1.10	-0.23	-17%
Befriending	217	1.37	1.21	-0.16	-12%
Counselling	28	1.18	0.86	-0.32	-27%
Transport	192	1.22	1.16	-0.06	-5%
Exercise in the home/community	78	1.78	1.27	-0.51	-29%
Carer intervention	147	1.32	1.22	-0.10	-8%
Complementary therapy	145	1.33	0.79	-0.54	-40%
Dementia support	65	0.97	1.09	0.12	13%
Advocacy	86	1.71	1.35	-0.36	-21%

Change within different sub-categories

From the data presented two subcategories stand out - age and referral outcome - and there were also some interesting variations according to support category.

Age

There are some significant differences in the change experienced by Social Prescribing Service users according to age, with younger Service users generally recording greater reductions in their use of urgent care than older Service users. For the cohort of service users aged under 80 (n=513) the overall change was greater than for the full cohort:

- The average number of non-elective inpatient episodes changed from 1.49 in the 12-month period before referral to Social Prescribing to 1.20 in the 12 months following referral: an overall reduction of 19 per cent (0.28).
- The average number of non-elective inpatient spells changed from 1.19 in the 12-month period before referral to Social Prescribing to 0.95 in the 12 months following referral: an overall reduction of 20 per cent (0.23).
- The average number of non-elective inpatient bed days changed from 7.43 in the 12-month period before referral to Social Prescribing to 7.72 in the 12 months following referral: an overall increase of four per cent (0.28). However, this change was **not statistically significant.**
- The average number of Accident and Emergency attendances changed from 1.46 in the 12-month period before referral to Social Prescribing to 1.12 in the 12 months following referral: an overall reduction of 23 per cent (0.34).

Overall, the cohort aged under 80 were more likely to have had an urgent care intervention in the 12 months prior to their Social Prescribing referral than those aged over 80. This suggests that many patients over 80 are scoring high on the risk register, and being identified for case management and referral to Social Prescribing, for reasons other than their use of urgent care. As such, it is not surprising that reductions in urgent care use amongst this age group have been less pronounced.

Referral outcome

For Service users who experienced a 'positive referral outcome' a greater amount of positive change was evident. Two types of positive outcome were explored: completing the programme of grant-funded referral activity, and continuing to access voluntary and community sector service provision once the initial referral activity was completed. For **Service users who completed their referral activity**:

- The average number of non-elective inpatient episodes changed from 1.25 in the 12-month period before referral to Social Prescribing to 1.10 in the 12 months following referral: an overall reduction of 12 per cent (0.15).
- The average number of non-elective inpatient spells changed from 1.02 in the 12-month period before referral to Social Prescribing to 0.87 in the 12 months following referral: an overall reduction of 14 per cent (0.15).
- The average number of non-elective inpatient bed days changed from 6.77 in the 12-month period before referral to Social Prescribing to 8.89 in the 12 months following referral: an overall increase of 31 per cent (2.11). However, this change was **not statistically significant**.

- The average number of Accident and Emergency attendances changed from 1.37 in the 12-month period before referral to Social Prescribing to 1.03 in the 12 months following referral: an overall reduction of 25 per cent (0.34).

For **Service users who continued to access VCS provision after completing their referral activity**:

- The average number of non-elective inpatient episodes changed from 0.97 in the 12-month period before referral to Social Prescribing to 0.47 in the 12 months following referral: an overall reduction of 52 per cent (0.51).
- The average number of non-elective inpatient spells changed from 0.78 in the 12-month period before referral to Social Prescribing to 0.38 in the 12 months following referral: an overall reduction of 51 per cent (0.40).
- The average number of non-elective inpatient bed days changed from 4.22 in the 12-month period before referral to Social Prescribing to 2.42 in the 12 months following referral: an overall reduction of 43 per cent (1.81).
- The average number of Accident and Emergency attendances changed from 1.03 in the 12-month period before referral to Social Prescribing to 0.67 in the 12 months following referral: an overall reduction of 35 per cent (0.36).

Support category

When the data were explored by grant-funded support category, the picture was less consistent across different types of urgent care activity, but interesting patterns were evident. For **non-elective inpatient episodes and spells**:

- Service users who had accessed information and advice, community leisure and social activities, and advocacy support witnessed larger than average reductions.
- Service users who had accessed enabling, befriending, exercise in the home/community, carers support and dementia support experienced an overall increase.

For **Accident and Emergency attendances**:

- Service users who had accessed information and advice, exercises in the home/community, complementary therapy and advocacy support witnessed larger than average reductions.
- Service users who had accessed dementia support experienced an overall increase, whilst for those who had accessed enabling, transport, or a carer intervention the reduction was lower than the average.

Conclusion

Overall, the analysis of patient-level Hospital Episodes Statistics reflects positively on the effectiveness of Social Prescribing at reducing urgent care utilisation amongst Service users. There is an **overall trend that points to reductions in patients' use of hospital resources** after they had been referred to Social Prescribing. Furthermore, for certain types of Service users the reductions were more pronounced:

- Service users aged under 80 experienced a larger average reduction than Service users over 80.
- Service users who completed their grant-funded referral activity within the VCS experienced a higher degree of positive change than those who did not.

- Service users who completed their grant-funded referral activity *and* continued to engage in the VCS once this activity had concluded exhibited the greatest amount of change.

These findings have some important implications for the Social Prescribing Service going forward. In particular, they highlight the importance of Service users engaging fully in and completing the VCS referral activity *prescribed* for them and the importance of ongoing engagement with the VCS once their funded activity is completed. Going forwarded, there is clearly value to be gained by the Social Prescribing Service and key referral points, particularly Case Management Teams, working to ensure that the types of people referred to Social Prescribing are those who are able to engage fully in order to experience the greatest benefit from the types of service available.

3.3. Understanding the limits of the analysis presented

The analysis presented of Social Prescribing Service users' use of urgent care hospital resources is the most robust to date: more than 900 Social Prescribing Service users have been tracked through two years of hospital data and changes in their use of urgent care observed. However, it should be noted that there are some important limitations, linked to the absence of a control or comparison group.

The use of a control or comparison group is important for estimating what might have happened in the absence of the intervention (the 'counterfactual'). It is particularly important in the context of interventions designed to reduce health service utilisation as the patients offered such interventions usually have previously experienced high levels of service use. Such patients have a natural tendency to show reductions in service use over time, even in the absence of a specific intervention.[14] This is due to a statistical phenomenon called 'regression to the mean'. Although the Social Prescribing Service receives referrals on the basis of a predictive model that seeks to take account of this phenomenon, reductions in service use over time are nevertheless possible and should be accounted for with a control or comparator group wherever possible in order to balance both observed and unobserved characteristics between different groups.[15] For this evaluation, however, it has only been possible to evaluate the effect on patients who had already received the intervention. Other similar studies[16] have used large administrative data sources to select control groups of patients that appeared similar to their intervention group patients in the period prior to the start of the intervention, but who did not receive the intervention themselves.

The Evaluation Team is currently exploring the possibility of accessing administrative data from the Health and Social Care Information Centre (HSCIC) in order to develop an external control group. However, it has not been possible to access the data in time for the publication of this report. If these comparator data become available the Evaluation Team may publish an updated analysis of the data and revise the evaluation findings accordingly.

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

4

Social impact

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

4.1. Well-being outcomes

The Social Prescribing Service measured users' progress towards social outcomes through a well-being measurement tool developed specifically for the Service. The tool was completed by VCSAs with users when they were first referred to the Service (baseline) with progress measured after approximately 3-4 months (follow-up). It has eight measures associated with different aspects of self-management:[17]

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

An overview of these outcome data is provided in Table 4.1 with more detailed analysis discussed in the sections that follow.

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

Table 4.1: Overview of well-being outcome baseline and distance travelled data

Outcome area	Baseline			Distance travelled			
	Count	Mean	Low scores* (per cent)	Count	Mean	Progress made	
						All (per cent)	*Low scores (per cent)*
Feeling positive	1,842	3.09	35	1,067	3.61	35	65
Lifestyle	1,843	3.33	22	1,068	3.68	26	59
Looking after yourself	1,843	3.58	18	1,068	3.91	23	57
Managing symptoms	1,843	3.25	25	1,068	3.55	23	52
Work, volunteering and social groups	1,841	2.69	42	1,065	3.32	46	57
Money	1,842	3.86	14	1,067	4.35	28	71
Where you live	1,843	3.97	11	1,068	4.36	24	68
Family and friends	1,843	3.78	14	1,068	3.99	19	63

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

Baseline analysis

Between September 2012 and March 2015 baseline data were collected for 1,843 users who were referred to Social Prescribing. In summary these baseline data show that:

- **Feeling positive:** the average score was 3.1; 35 per cent of Service users recorded a low score (of two or less)
- **Lifestyle:** the average score was 3.3; 22 per cent recorded a low score
- **Looking after yourself:** the average score was 3.6; 18 per cent recorded a low score
- **Managing symptoms:** the average score was 3.3; 25 per cent recorded a low score
- **Work, volunteering and other activities:** the average score was 2.7; 42 per cent recorded a low score
- **Money:** the average score was 3.9; 14 per cent recorded a low score
- **Where you live:** the average score was 4.0; 11 per cent recorded a low score
- **Family and friends:** the average score was 3.8; 14 per cent recorded a low score.

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

Distance travelled analysis

Of the 1,843 Service users for whom baseline data had been collected 1,068 had been followed-up after 3-4 months. It is on the progress, or 'distance travelled', of these 1,068 users that the remaining well-being outcome analysis focusses.

Overall, **82 per cent of Service users experienced positive change** on at least one outcome measure. The results are broken down by outcome category in figure 4.1 which shows that progress was made against each outcome measure and that a majority of low-scoring Service users (with a baseline score of two or less) made progress:

- **Feeling positive:** 35 per cent made progress; of the users with a low baseline score 65 per cent made progress.
- **Lifestyle:** 26 per cent made progress; of the users with a low baseline score 59 per cent made progress.
- **Looking after yourself:** 23 per cent made progress; of the users with a low baseline score 57 per cent made progress.
- **Managing symptoms:** 23 per cent made progress; of the users with a low baseline score 52 per cent made progress.
- **Work, volunteering and other activities:** 46 per cent made progress; of the users with a low baseline score 57 per cent made progress.
- **Money:** 28 per cent made progress; of the users with a low baseline score 71 per cent made progress.
- **Where you live:** 24 per cent made progress; of the users with a low baseline score 68 per cent made progress.
- **Family and friends:** 19 per cent made progress; of the users with a low baseline score 63 per cent made progress.

Statistical testing[18] was undertaken to explore the statistical significance of the proportion of Social Prescribing Service users moving from a low baseline score to a high score (of 3-5) when followed-up. This showed that the change was statistically significant for all outcome measures. This provides a high degree of confidence that the outcome change observed represents real change, and did not occur due to random chance. The distance travelled by Social Prescribing Service users across a range of outcomes after a relatively short period demonstrates the potential of social interventions to address some of the key psycho-social determinants of health. That most progress was made against the lowest-scoring outcome areas (work, volunteering, etc., and feeling positive); and that a majority of low-scoring users made progress; reflects positively on both the effectiveness of the Social Prescribing assessment and referral process and the ability of commissioned services to meet the specific social needs of Service users.

Table 4.2 shows the 'distance travelled' on each measure by a number of sub-groups, focussing on the proportion of Service users who made progress on at least one outcome measure. Overall, it shows a fairly consistent pattern, with two key exceptions:

[18] 95 per cent confidence intervals were applied. The McNemar test was applied to identify statistically significant change between baseline and follow-up outcome scores for each outcome category

- **Referrals-out:** a lower proportion of Service users who were only referred-out to non-VCS services (74 per cent), or only received signposting information (66 per cent), recorded progress on at least one outcome, when compared to Service users who were referred out to VCS services (at least 84 per cent).
- **Referral outcomes:** higher proportions of Service users who completed their grant-funded referral activity within the VCS (88 per cent) and who completed their grant-funded referral activity and continued to engage in the VCS once this activity had concluded (94 per cent) recorded progress on at least one outcome, when compared to Service users whose referral outcome was less positive.

Figure 4.1: Overview of well-being distance travelled data by outcome category

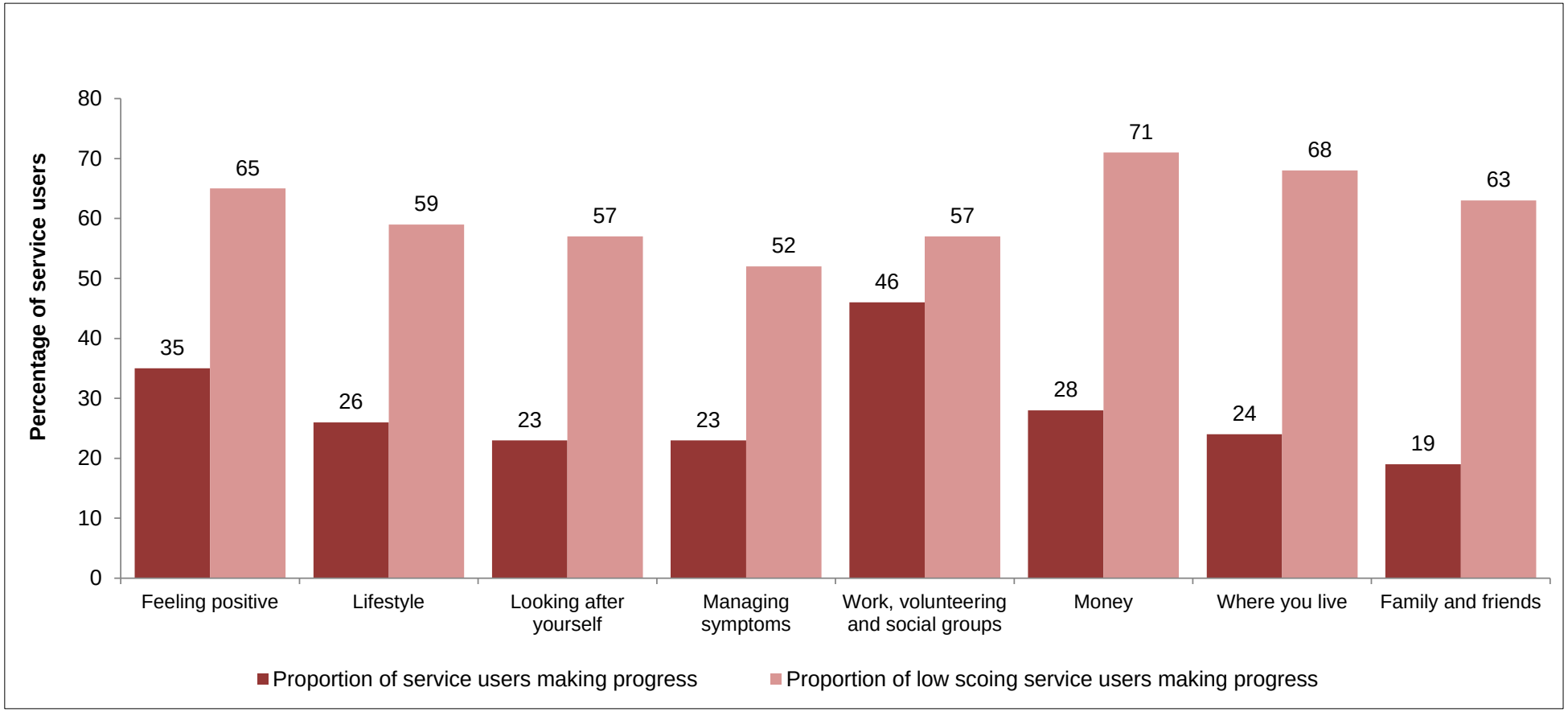


Table 4.2: Overview of well-being distance travelled data by sub-groups: proportion of participants making progress on at least one outcome

	Base	Proportion of participants making progress on at least one outcome
All Service users	1,067	83
Referrals-out:		
Referred-out to any service	1024	83
Referred-out to a grant-funded service	875	85
Referred-out to any type of VCS service	962	84
Referred-out to non-VCS services only	62	74
Signposted-out only	44	66
Referral outcome:		
Service user completed referral activity	667	88
Service user continued to access VCS services when the initial service ended	120	94
Gender:		
Male	404	82
Female	664	83
Age:		
Under 80 only	606	84
Under 50	54	85
50-59	88	82
60-69	137	88
70-79	327	83
80-89	368	82
90 or over	88	80
Support category:		
Information and advice	453	87
Enabling	161	86
Community Activities Co-ordinator	140	89
Community leisure and social activities	463	81
Befriending	259	88
Counselling	38	82
Transport	227	82
Exercise in the home/community	144	81
Carer intervention	156	84
Complementary therapy	170	81
Dementia support	83	86
Advocacy	112	88

4.2. Case study findings

Part of this evaluation involved conducting three qualitative case studies with social prescribing services. Each service was taken as a case, and within that, interviews were undertaken with key management and delivery staff members (7 interviews), volunteers (2 interviews) and Service users (6 interviews). In addition, follow-up interviews were undertaken with 5 Service users who participated in case studies in the previous evaluation reports, to understand how their lives had changed since. and to identify if any of the benefits had been sustained.

These case studies have provided more detailed evidence of social outcomes experienced by Social Prescribing Service users. An overview of this evidence is provided in the following sections, grouped around the four broad outcomes of increased well-being, reduced social isolation and loneliness, increased independence, and access to wider welfare benefits. In addition, more detailed case study reports are provided in Appendix 1.

Improved well-being and quality of life

Service users described the way in which Social Prescribing services had improved their physical and mental well-being. Some Service users discussed improvements in their physical health due to physical activities, and others explained that activities provided them with an opportunity to try new activities. For example, Mr D explained that the physical activity sessions he was attending provided him with the opportunity to "*try something new. You learn new skills, or have a go at reviving old ones anyway.*"

Improvements to mental well-being were particularly significant for a number of people accessing Social Prescribing services. For example, Mrs A discussed how important the service had been for her since a period of ill health:

> *"It's a downward spiral when you've had strokes, because you lose your energy levels, it blows your mind. And you feel completely useless."* (Mrs A)

For Mrs A, the link with a member of staff within a Social Prescribing service had been extremely important to her during her recovery, describing how "*she had this ability to make me feel as if I was worthwhile.*" She reflected how the intervention had made a difference to her feeling able to cope with day-to-day activities, and crucially how she felt about herself, "*to the stage where I'm climbing back up to being [myself*]."

Staff and volunteers within service-providing organisations also discussed the improvements to the well-being of Service users that they perceived, such as a change in mood, or a change in how much users will talk. One service provider talked about the shift that staff or volunteers notice in Service users, which signals that an intervention is working:

> *"It's a shift, and I think it's the volunteer that notices the shift. And actually I think sometimes family members do, they'll comment on 'oh she seems a lot happier since you started going…"* (Service provider)

Grant-funded Social Prescribing Service providers talked about the ways in which Service users were gaining confidence through the support they were receiving. In one particular instance, a member of staff discussed an example from her service, where a Service user had taken on responsibility within a group she was attending:

"I had a lady that I was going to visit, and she went to a craft club…a community thing. She was a bit reticent, but she went. And she ended up, I think the person that was running the craft group was poorly herself, and I know she ran one of the classes, so she actually stepped up." (Service provider)

Reduced social isolation and loneliness

As well as the improvements in well-being, service staff and volunteers discussed the ways in which the services they delivered helped to reduce social isolation and loneliness. A common theme across services was that Social Prescribing interventions often provided companionship, enabling Service users to talk to someone who was interested in them and their well-being.

"It's the talking and the listening that you feel is of benefit…because after you've seen them for a couple of weeks, they'll often say things and open up, not necessarily to get an answer, but just to air something." (Social Prescribing volunteer)

Service users who had been enabled to start attending activity groups also talked about the reduction in isolation, and the importance of having a regular group to go along to. For example, Mr B explained the significance of an activity group he regularly attends, which is a session to support physical activity, but which in fact also helps to reduce his loneliness:

"It keeps you going. It gets you out of the house. A lot of us live on our own, so it gets us out. Otherwise we'd be stuck at home." (Mr B)

The importance of Service users making new social links was raised by a number of staff, volunteers and Service users interviewed. One volunteer explained how important it had been for one of the Service users she had been visiting.

"I got her to go to knit and natter, through that meeting a lot of people, and not necessarily people in her situation, is wasn't all old and infirmed people, or ill people. And they're a very good group, so I really felt strongly that I was pleased that she would continue doing that. I took her a couple of times, and she has continued doing it." (Social Prescribing volunteer)

In a number of cases there were wider benefits which Service users discussed. In some cases Service users that have received services through Social Prescribing have become volunteers within those services. This illustrates the extent to which these services have helped to enable people to make a real transition in order to engage in activities, and then go on to support others. It also demonstrates added value.

Increased independence

A number of Service users and service providers discussed improvements to levels of independence as a result of Social Prescribing services. This was often discussed in terms of increased levels of confidence to take public transport, or learning how to access community transport. Staff from services provided a number of examples of Service users that had experienced significant changes in their levels of independence. For example, this member of staff from a Social Prescribing Service described a particular case whereby public transport had been a barrier:

"One lady, we actually met at a bus stop, so the first day we went to the bus stop, she went from home to the bus stop with the volunteer, went on the bus to the place she wanted to go. And the second time, she met the volunteer at the bus stop. And the next time she was supposed to meet her there, but she wasn't

confident enough so they met at the bus stop again. But by the end of it she was independently going to that activity. So that was a big leap forward." (Service provider)

Service users also described the ways in which they felt their independence growing. For example, Mrs A was struggling to leave the house following a stay in hospital. Since being referred to the Social Prescribing Service, she has been able to access transport in order to start regularly attending a support group.

In some groups, as friendships develop, Service users develop support networks whereby they will share lifts to and from groups. For example, Mrs C usually relies on her mobility scooter in order to attend a particular group. She explained wet weather prevents her using her scooter, which would in turn prevent her attending. However, another Service user within the same group has started collecting Mrs C, enabling her to attend.

Some Service users described the way in which attending activities through Social Prescribing has in turn opened up new opportunities. Since starting a physical activity group, Mrs A now accesses a broad range of opportunities within the area.

Volunteers also reflected on the changes they perceived in Service users and their levels of independence. Two volunteers within one service explained how they both accompanied Service users on initial visits to groups, but they had been heartened to see how they were now travelling independently, and making friends. Volunteers continued to 'check-in' with Service users, sometimes in person and sometimes over the phone, but often the need to accompany Service users to groups was only required at the start.

Access to wider welfare benefits

An important aspect of the Social Prescribing Service is the work being done to support users in accessing a range of welfare benefits to which they are entitled. The role of Social Prescribing services was vital, as advice and support not only helped users to understand their situation, but also helped in many cases with completing applications.

One member of staff within a Social Prescribing service explained that she was often helping people who wouldn't necessarily visit advice centres, or sought help previously:

"Often it was people who didn't know anything about benefits, and probably wouldn't consider going to benefits offices or advice centres. So to some extent I think the referral system has tapped a new source of claimant, because a lot of the, certainly a lot of the benefits I deal with aren't means tested, you know, a lot of disability benefits, AA, DLA tend not to means test, and a lot of people, perhaps older people especially think 'I've got money in the bank, or I've got income, I won't qualify." (Service provider)

5 Economic and social cost-benefits

This chapter provides a monetised assessment of the economic and social cost-benefits of the Rotherham Social Prescribing Service. The economic cost-benefits are estimated based on analysis of Service users' use of urgent hospital care (Chapter 3). Social cost-benefits (social value) are estimated based on analysis of the Service's social impact (Chapter 4), using well-being outcome data.

5.1. The costs of Social Prescribing (inputs)

Overall the Social Prescribing Service costs just over £0.5 million per year. A more detailed breakdown is provided in Table 5.1.

Table 5.1: Overview of Social Prescribing Service Costs (2012-15)

	Year 1 (Apr 12-Mar 13)	Year 2 (Apr 13-Mar 14)	Year 3 (Apr 14-Mar 15)	Total
Grants to providers	£301,727	£204,540	£288,219	£794,486
Additional support grants	£11,265	£93,066	£8,657	£112,988
Core Service costs (salaries/overheads, etc.)	£216,182	£273,012	£251,004	£740,198
Total	£529,174	£570,618	£547,880	£1,647,672

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

- **Voluntary Action Rotherham and the CCG** invested a significant amount of time prior to the commissioning of the Pilot to research need for the Service, develop the Service model and specification, and consult with GPs and voluntary sector organisations. In addition, they continue to invest time promoting the Service. This includes within their organisations, partnerships and sectors, and in areas beyond Rotherham who are interested in learning about Social Prescribing. Many of these activities are not covered by the direct costs of commissioning the Service.

- **The Foundation Trust** supported the development of a complex client management system (database) through which referrals in to and out of the Service were monitored and reported on. Support for the maintenance and ongoing development of this system is ongoing.
- **Volunteers:** many of the services provided through the Service were provided with considerable support from volunteers. They input their own time, without which the direct costs of delivering the Service would have been far higher.

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

5.2. The economic benefits of the Social Prescribing Service

This section considers the economic cost-benefits (costs avoided) of the Social Prescribing Service. Two types of NHS cost avoidance are considered:

- non-elective hospital admissions (inpatient spells)
- Accident and Emergency attendances.

It is important to note that these estimates should not be compared to previous evaluation reports due to the changes in methodology described in Chapter 3.

Methodology

Activity was costed using the NHS reference costs for inpatient spells and Accident and Emergency attendances.[19] These costs represent the average unit cost to the NHS of providing secondary healthcare to NHS patients.

Following the calculation of costs, analysis was undertaken on similar basis to that presented in Chapter 3. The estimated cost of each type of episode was compared for the 12-month periods before and after referral to Social Prescribing.

Analysis

An overview of the estimated changes in costs is provided in Table 5.2. It provides a figure for the estimated total cost of urgent care interventions (i.e. spells and Accident and Emergency presentations) for the 12 months before and after referral to Social Prescribing, and the change in those costs in real and per Service user (i.e. average/mean) terms. Sub-category data are also provided for different types of referral-out, referral outcome, gender, age and support category.

[19] NHS Reference Costs are available online at https://www.gov.uk/government/collections/nhs-reference-costs

Table 5.2: Estimated total cost of urgent care interventions for the 12 months before and after referral to Social Prescribing

	Base	Sum of spell and Accident and Emergency costs			
		12m before	*12m after*	*Change*	*Change per Service user*
All Service users	939	£2,210,432	£1,957,468	-£252,964	-£269
Referrals-out:					
Referred-out to any service	869	£2,097,400	£1,824,624	-£272,776	-£314
Referred-out to a grant-funded service	722	£1,686,528	£1,528,076	-£158,452	-£219
Referred-out to any type of VCS service	810	£1,941,788	£1,705,680	-£236,108	-£291
Referred-out to non-VCS services only	59	£155,612	£118,944	-£36,668	-£621
Signposted-out only	70	£113,032	£132,844	£19,812	£283
Referral outcome:					
Service user completed referral activity	555	£1,316,676	£1,116,492	-£200,184	-£361
Service user continued to access VCS services when the initial service ended	73	£132,420	£66,556	-£65,864	-£902
Gender:					
Male	357	£953,336	£813,816	-£139,520	-£391
Female	582	£1,257,096	£1,143,652	-£113,444	-£195
Age:					
Under 80 only	513	£1,406,032	£1,127,540	-£278,492	-£543
Under 50	42	£168,488	£119,832	-£48,656	-£1,158
50-59	76	£223,976	£181,624	-£42,352	-£557
60-69	134	£382,192	£321,124	-£61,068	-£456
70-79	261	£631,376	£504,960	-£126,416	-£484
80-89	329	£620,296	£612,380	-£7,916	-£24
90 or over	85	£138,352	£199,452	£61,100	£719
Support category:					
Information and advice	331	£840,428	£739,664	-£100,764	-£304
Enabling	159	£457,336	£457,884	£548	£3
Community Activities Co-ordinator	114	£260,944	£244,708	-£16,236	-£142
Community leisure and social activities	435	£1,041,636	£910,436	-£131,200	-£302
Befriending	217	£494,872	£525,092	£30,220	£139
Counselling	28	£51,612	£39,696	-£11,916	-£426
Transport	192	£467,496	£446,568	-£20,928	-£109
Exercise in the home/community	78	£196,516	£219,636	£23,120	£296
Carer intervention	147	£354,536	£359,156	£4,620	£31
Complementary therapy	145	£270,172	£245,380	-£24,792	-£171
Dementia support	65	£107,172	£118,964	£11,792	£181
Advocacy	86	£286,068	£245,504	-£40,564	-£472

These data show that for all Service users who engaged substantively with Social Prescribing between September 2012 and March 2014 there was an **estimated overall reduction of £0.25m** compared to input costs from commissioners of around £1.1 million. This translates to **reductions of £269 per Service user** set against per-Service user input costs of £1,171. It also shows some significant variations by sub-category, mirroring the analysis presented in Chapter 3. In particular, it shows that the per-Service user reductions were significantly high for:

- Services users who completed their referral activity: £361
- Service users who continued to access VCS provision after completing their referral activity: £902
- Service users aged under 80: £543.

These cost change data provide the basis for an estimate of the annual economic return on investment to the NHS presented in the following section.

Estimated return on investment

Taking the estimated reduction £269 per Service user it is possible to present an overall estimate of return on investment associated with each year of the Social Prescribing Service and the three years combined. This is presented in table 5.3 below.

Table 5.3: Estimated annual return on investment (ROI) from NHS cost reductions

	No of Service users engaged	Costs	Benefits	ROI
Year 1 (Apr 12-Mar 13)	218	£529,174	£58,642	£0.11
Year 2 (Apr 13-Mar 14)	779	£570,618	£209,551	£0.37
Year 3 (Apr 14-Mar 15)	994	£547,880	£267,386	£0.49
All years	**1,991**	**£1,647,672**	**£535,579**	**£0.33**
Year 2 and 3 mean	887	£559,249	£238,469	£0.43

This demonstrates that the **estimated annual NHS costs avoided for the full three years of the service is £536,000** compared to total input costs of £1.65 million. This translates to an annual return on investment of 0.33 (33 pence for each pound invested). However, it is important to note that the Year 1 figures do not provide an accurate reflection of the likely cost-benefits of Social Prescribing over a longer period. This is because of the considerable time that elapsed between the commissioning of the Pilot and the first referrals-in (circa five months) and the first referrals-out (circa eight months). As such the number of referrals was far lower than in Years 2 and 3 of delivery which encompassed full 12-month periods. Therefore, when considering the likely cost-benefits that will occur during future years of delivery it would more realistic to use an average (mean) of the Year 2 and 3 figures rather than the combined figured for all three years. This provides a much higher estimated annual return on investment of 0.43 (43 pence for each pound invested).

Using these figures as a basis for longer-term projections, and assuming that the benefits identified are sustained over a longer period, **the costs of delivering the service for a year could be recouped by commissioners after two and a half years**. Table 5.4 demonstrates how these annual benefits might accumulate over a longer period (up to five years).

Table 5.4: Estimated long-term return on investment (ROI) from NHS cost reductions

	1: Benefits last for 5 years		2: Benefits drop-off at 20 per cent per year		3: Benefits drop-off at 33 per cent per year	
	Cumulative value	ROI	Cumulative value	ROI	Cumulative value	ROI
Year 1	£238,469	£0.43	£238,469	£0.43	£238,469	£0.43
Year 2	£468,591	0.84	£422,566	0.76	£390,349	0.70
Year 3	£690,366	1.23	£555,632	0.99	£463,535	0.83
Year 4	£903,796	1.62	£641,003	1.15	-	-
Year 5	£1,108,879	1.98	£682,020	1.22	-	-

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

- If the full benefits last for five years they could lead to total costs avoided of £1.1 million: a return on investment of 1.98 (one pound and 98 pence for each pound invested).
- If the benefits are sustained but drop-off at a rate of 20 per cent each year they could lead to total costs avoided of £0.68 million: a return on investment of 1.22 (one pound and 22 pence for each pound invested).
- If the benefits are sustained but drop-off at a rate of 33 per cent each year they could lead to total costs avoided of £0.46: a return on investment of 0.83 (83 pence for each pound invested).

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

This section considers the social cost-benefits, or social value, of the Social Prescribing Service. It uses financial proxies to provide a monetised assessment of social impact arising from the Service based on analysis of the well-being outcome data discussed in Chapter 4.

The approach to monetising well-being draws on social value work undertaken by the New Economics Foundation and New Economy Manchester[20] to value the subjective well-being benefits associated with social interventions. Well-being is equated with mental health to enable the use of health economics to monetise the

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

social value created. Analysis by the Centre for Mental Health[21] placed a cost on mental illness through the use of QALYs (Quality Adjusted Life Years), derived from a measure of health-related quality of life. Their analysis identified the average loss of health status in QALYs from a level-three mental health problem (a severe problem - 0.352 QALYs) and valued this by using the NICE (National Institute for Health and Care Excellence) cost effectiveness threshold of £30,000 per QALY. Equating well-being with mental health therefore provides an overall well-being valuation of £10,560 per year (0.352 x £30,000). As the Service did not use a recognised QALY-based social value tool (such as EQ-5D), the well-being outcome tool was used as a proxy measure of well-being and health-related quality of life.

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

Methodology

As a start point, it was assumed that each category on the well-being outcome tool provided an equal contribution to well-being. As such, the total value of well-being was distributed evenly across the outcomes (£1,320 per outcome). Two approaches to valuing the well-being benefits were then taken. In the first approach, all outcome change was valued, and it was assumed that a one point change on each outcome measure equated to 20 per cent of the outcome value. In this approach a Service user progressing one point on an outcome measure accrued £264 of social value while a Service user progressing five points accrued £1,320. In the second approach 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 5.5.

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

Table 5.5: Allocation of financial proxies

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

An estimate of the well-being value created

An overview of the estimated well-being value created for users of the Social Prescribing Service is provided in Tables 5.6 and 5.7. The total value was calculated by multiplying the per-user value by the total number of users substantively engaged by the Service across each year of the Service (Year 1=218; Year 2=779; Year 3=994).

Table 5.6: 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	Year 1 value	Year 2 value	Year 3 value	Per Service user value	Year 1 value	Year 2 value	Year 3 value
Feeling positive	£107	£23,409	£83,650	£106,737	£172	£37,487	£133,956	£170,927
Lifestyle	£60	£13,149	£46,985	£59,953	£66	£14,280	£51,029	£65,113
Looking after yourself	£58	£12,610	£45,059	£57,496	£52	£11,316	£40,438	£51,599
Managing symptoms	£44	£9,592	£34,276	£43,736	£58	£12,664	£45,252	£57,741
Work, volunteering and social groups	£151	£33,018	£117,987	£150,550	£180	£39,179	£140,001	£178,640
Money	£99	£21,629	£77,290	£98,621	£77	£16,721	£59,750	£76,241
Where you live	£74	£16,166	£57,769	£73,712	£36	£7,814	£27,921	£35,628
Family and friends	£54	£11,694	£41,786	£53,319	£63	£13,741	£49,103	£62,656

Table 5.7: Overview of the estimated annual well-being value created by year

	1: Valuing all outcome change	2: Valuing low to high outcome change
Year 1 (Apr 12-Mar 13)	£141,267	£153,202
Year 2 (Apr 13-Mar 14)	£504,801	£547,450
Year 3 (Apr 14-Mar 15)	£644,124	£698,544
All years	**£1,290,192**	**£1,399,195**

It shows that the two approaches to valuation provided very similar results: valuing all outcome change produced an estimated total annual well-being value of £1.29 million; valuing only low-to-high outcome change produced an annual value of £1.40 million These values can be compared with the costs of delivering the Social Prescribing Service to provide an estimate of the annual return on investment provided (Table 5.8).

Table 5.8: Estimated annual 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
Year 1 (Apr 12-Mar 13)	218	£529,174	£141,267	£0.27	£153,202	£0.29
Year 2 (Apr 13-Mar 14)	779	£570,618	£504,801	£0.88	£547,450	£0.96
Year 3 (Apr 14-Mar 15)	994	£547,880	£644,124	£1.18	£698,544	£1.27
All years	**1,991**	**£1,647,672**	**£1,290,192**	**£0.78**	**£1,399,195**	**£0.85**
Year 2 and 3 mean	887	£559,249	£574,463	£1.03	£622,997	£1.11

This demonstrates that the estimated return on investment from well-being benefits for the full three years of the Service was between 0.78 and 0.85 (between 78 pence and 85 pence per pound invested). As with the NHS cost reductions, it is important to note that the Year 1 figures do not provided an accurate reflection of the likely social cost-benefits of Social Prescribing over a longer period. This is because of the considerable time that elapsed between the commissioning of the Pilot and the first referrals-in (circa 5 months) and the first referrals-out (circa 8 months). As such the number of referrals was far lower than in Years 2 and 3 of delivery which encompassed full 12-month periods. Therefore, when considering the likely social cost-benefits that will occur during future years of delivery it would more realistic to use the average (mean) figures for Year 2 and 3 combined rather than the combined

figure for all three years. This provides a much higher estimated annual social benefits of between £0.57 million and £0.62 million: a social return on investment of between 1.03 and 1.11 (between one pound and three pence and one pound and 11 pence for each pound invested). This means that **a positive social return on investment based on the well-being benefits experienced by Service users is achieved** during the first year post-referral.

6 Conclusion

This report has provided a detailed assessment of the economic and social impact of the Rotherham Social Prescribing Service for people with long-term conditions. It builds on two earlier evaluation reports which identified the emerging lessons from and impact of the Pilot. This concluding chapter highlights the findings from the evaluation to date and outlines some next steps for the evaluation moving forward.

1. The Rotherham Social Prescribing Service is one of the largest and highest profile examples of social prescribing in the UK

By committing more than £1.6 million to Social Prescribing between 2012 and 2015, NHS Rotherham CCG and its statutory partners have made a large and long-term financial and strategic commitment to Social Prescribing as a mainstream component of health provision in the borough. As such, it is one of the largest and highest profile examples of social prescribing in the UK and has received national recognition for the work being undertaken, and provides an aspirational model of service delivery for other parts of the country.

Central to the Rotherham Social Prescribing model is role of VAR - the local voluntary sector infrastructure body - as the single accountable contract holder independent from frontline service delivery, and the micro-commissioning of specific social prescribing activities from the local voluntary and community sector that enable service users to access support that is tailored to their needs.

2. In the past three years the Service has engaged with more than 2,000 local people with long-term health conditions

The Service has substantively engaged with more than 2,000 local people with long-term health conditions since 2012. Grant-funded social prescribing services have provided these Service users and their carers with an important first step to engaging with community-based services and wider statutory provision that they would not otherwise have been aware of or able to access.

3. There is growing evidence that Social Prescribing can have positive effect on the use of urgent and emergency health services

Overall, Social Prescribing users had fewer non-elective inpatient episodes and spells and fewer Accident and Emergency attendances in the 12 months following their engagement with the Service than in the 12 months prior to engagement. However, at this moment it is not possible to fully attribute these reductions to Social Prescribing interventions due to the absence of a suitable control or comparator group.

4. Social Prescribing impacts positively on people's well-being

There is overwhelming quantitative and qualitative evidence that people receive an immediate boost to their well-being following their engagement with Social Prescribing, and the qualitative longitudinal evidence suggests that these benefits are sustainable. Social Prescribing appears to be particularly effective at improving well-being and reducing social isolation and loneliness for people with long-term conditions, enabling them to become more independent and engaged in their community

5. There are number of cost-benefits to Social Prescribing, but the effect of these should be understood over a long-term timeframe

Overall, Social Prescribing Service users used fewer NHS urgent care resources in the 12 months following their engagement with the Service when compared to the previous 12 months. Across the first three years of the service this reduction equates to estimated NHS costs avoided of more than half a million pounds: an initial return on investment of 43 pence for each pound (£1) invested. However, these reductions would need to be sustained for at least two and a half years for the cost of delivering the Service to be recouped.

The social benefits to Service users accrue a faster rate. The estimated social value of the well-being benefits experienced by Service users was between £0.57 million and £0.62 million in the first year following engagement with Social Prescribing: greater than the costs of delivering the service.

6. There is growing evidence that Social Prescribing has a greater effect for people who are able to engage fully, and who continue to engage with the VCS beyond their initial 'social prescription'

The analysis undertaken for this report has consistently indicated that Service users whose engagement with Social Prescribing is most extensive are more likely to experience the benefits. Service users who completed their initial referral activity or activities are more likely to see a reduction in their use of urgent and emergency care, more likely to experience improvements in their well-being, and represent a much larger per-Service user cost-benefit than those who do not engage as fully. Within this group the benefits are particularly pronounced for Service users who completed their referral activity and continued to engage with the voluntary and community sector once this initial activity was complete.

This highlights the importance of the Social Prescribing Service and key referral points, particularly Case Management Teams, working to ensure that the types of people referred to Social Prescribing are those who are able to experience the greatest benefit from the types of service available.

7. There are a number of wider benefits and outcomes for the local voluntary and community sector associated with the Rotherham Social Prescribing Service that mean it provides considerable added value

Previous evaluation reports have highlighted the benefits of Social Prescribing for the local voluntary and community sector: the additional grant funding has improved organisational sustainability and enabled additional income to be generated from external sources including grant funders and national statutory bodies. More generally, the success of the Social Prescribing Service has demonstrated the ability of relatively small voluntary and community organisations to make a positive contribution to local strategic health and well-being priorities and improved the credibility of the sector with statutory partners.

8. Next steps for evaluation

Ongoing evaluation will need to track Social Prescribing Service users for a longer period post-referral. Although Service users need to be tracked for a minimum of 12 months post-referral to identify the immediate benefits of Social Prescribing, there is merit in tracking Service users for a longer period (at least 2-3 years) to understand the extent to which benefits drop-off, are sustained, or are enhanced. In addition, the development of a control or comparison group would improve the statistical reliability of any data analysis and should be a priority for future evaluative work. The Evaluation Team is currently exploring how national Hospital Episodes Statistics can be obtained and used to provide a matched-comparator for further analysis. Other areas future evaluation might consider include the impact on GP time, use of social and residential care and the introduction of a standardised measure of health-related quality of life.

Appendix 1: Case studies

A1

Case Study 1: British Red Cross

The organisation

The British Red Cross is a registered charity, established to support people in crisis both within the UK and abroad.

The Befriending Plus Service that the British Red Cross provide in the Rotherham area is funded through the Social Prescribing Service. Its key aim is to support people who have long term conditions who may be feeling lonely, isolated and depressed and to enable them to engage with activities in their local communities. The service allocates a volunteer to visit individuals with long term conditions for up to 10 times. The volunteer tries to support the individuals to improve their confidence and sense of well-being by getting them involved in activities whereby they can build their social networks and feel less isolated when the times comes for the volunteer to leave.

The service was designed using learning and experience from previous projects, but remained flexible in order to adapt to what was needed. The beneficiaries referred into the service are often, although not always, older people, many in their 80s and 90s. People referred are lonely and want some companionship. This service relies on rapport and the development of positive relationships between staff, volunteers and patients.

Successes

The interviews highlighted a number of successes for Social Prescribing Service users, which are summarised below:

Reduced social isolation

Both staff and volunteers talked about the value of this service in reducing social isolation, explaining that often beneficiaries just want to talk to someone, and feel that they have been listened to, and understood. For example:

> *"It's the talking and the listening that you feel is of benefit. because after you've seen them for a couple of weeks, they'll often say things and open up, not necessarily to get an answer, but just to air something.*" (Social Prescribing volunteer)

And:

> "*Stories they want to share. It is that kind of thing as well, enabling… giving them the time to tell their stories.*" (Social Prescribing service provider)

One staff member discussed the way in which often the first thing that was needed was to help the Social Prescribing Service user to feel more positive, and from here they could start to consider more activities.

Increased independence

Staff and volunteers discussed the ways in which they saw a gradual increase in independence over the weeks of the intervention. This was sometimes described in terms of Social Prescribing beneficiaries being able to access public transport, getting more actively involved in groups or building independent social networks. For example, a member of staff discussed how one Social Prescribing beneficiary had increased her independence:

> *"One lady, we actually met at a bus stop, so the first day we went to the bus stop, she went from home to the bus stop with the volunteer, went on the bus to the place she wanted to go. And the second time, she met the volunteer at the bus stop. And the next time she was supposed to meet her there, but she wasn't confident enough so they met at the bus stop again. But by the end of it she was independently going to that activity. So that was a big leap forward."*

Staff and volunteers interviewed also reflected on how they felt the Social Prescribing service itself was a positive model and intervention. These have been grouped into key headings, and are summarised below:

Partnerships

The relationship between this service and Voluntary Action Rotherham (VAR) was highlighted as a very positive aspect of the project, and in particular the advisors were mentioned in terms of the valuable link between the GPs and the individual voluntary organisations. One respondent pointed in particular to the workshops that VAR held, stating how useful these were in building awareness and individual relationships between services. Respondents did suggest that they would value more networking opportunities for referral organisations to get together.

> "*VAR hold several workshops, so we get a regular chance of meeting the other providers as well. So we get good networking opportunities.*" (Staff)

It was suggested that such events keep communications flowing between providers.

The work of VAR advisors was raised as a valued aspect of the social prescribing service:

> "*I think we have a really good relationship with VAR, because we have good contacts. We can phone the advisors, we can get in touch with the project manager. They're very open to you phoning up and asking questions, and clarifying things. So we've got really good communications there*." (Staff)

Volunteers

As well as providing a key aspect of this befriending service, the volunteers are also able to benefit from being involved in the service. This ranges from developing skills to forming new relationships. Volunteers talked about how they also benefit from being involved, with one talking about getting a lot out of meeting different people, being a friend, and providing her with opportunities to get out and meet different people. Volunteers expressed their surprise at what they, as well as the Service users, got out of the service.

The Social Prescribing model

Feedback

One respondent highlighted the positive aspects of the Social Prescribing model, in that it enabled the service to provide monthly feedback to VAR, which then fed through to GPs, so

that the service feels that the work is continually feeding into the Service users journey, providing much more of a complete picture of an individual's development.

> "*I really do like the social prescribing, because we see people for a longer period…and so you can spend as much time with that person, and because of the enabling aspect, we're trying to set them up to continue rather than just go in and visit, have a nice time, but then it stops. So because this has a focus of getting people to continue, taking them to a group rather than telling them about a group…I think it's much more satisfying when you're delivering that service and the outcome for the person it better.*" (Staff)

And:

> "*I like how VAR run it, because we have monthly reports from them, and we more or less give them case studies, because we tell them what we've done with a person every month, and then that information is then fed back to the GP because they're the one who are referring in the first place. So it's like a consistent study, there's a trail, a loop of it, and it's not throwing in a random case study at the end of a three month period when you do a report. Every month there's feedback given for every person we see. And so that goes back to VAR and they collate all that information from all the various strands of the social prescribing, and feed it back to the GP, so it gives a much more whole picture of that person.*" (Staff)

> "*I think it's a great model, I really do. It's such a good way of doing it.*" (Staff)

The service is proving to be a big help for GPs as they are now getting detailed feedback and can therefore see the difference that voluntary sector services can make:

> "*Doctors are actually seeing what the voluntary sector is doing*." (Staff)

Staff also stated that having VAR as the body that liaised with GPs worked very well as they had always found engaging with some GPs a challenge.

Flexibility

The ability of services to evolve over time, based on experience, was highlighted by one respondent as a very positive aspect of the Social Prescribing model. This has enabled services to be developed based on what does, and does not, work. Linked to this, volunteers reported that the flexible model enables them to work in different ways in order to meet the needs of each individual beneficiary, and adapting the service to each individual.

As well as the successes of the service, those who took part in interviews were asked about any challenges they felt the service faced. These are summarised below.

Challenges

Timescales

A common theme which was referred to was time constraint. Although it was noted that there had been a shift, from number of hours to number of visits (therefore potentially enabling more time per visit), the limit of 10 visits/20 hours was referred to in terms of staff and volunteers being unable to see the outcomes of the intervention. Volunteers in particular found this challenging, as they build rapport and relationships with individuals, and sometimes feel that their involvement has to stop prematurely.

Sustainability - cost of transport

One of the key priorities for this service is to support beneficiaries to build their confidence so that they can start to undertake activities without the support of a volunteer. The hope is that the Service user will then continue with the new activities beyond the 10 visits which

make up this intervention. However, one of the issues raised by staff delivering the service was the problem of the cost of community transport, and travel in general. People can be hesitant to start an activity which involves a taxi or community transport journey if they have concerns about how they will afford it in the longer-term. Although volunteers do encourage people to use buses where it is possible and appropriate, this isn't always the case (i.e. activities aren't always on bus routes, or the Service user is too frail).

Number of referrals for individual Service users

One interviewee talked about the issue of the number of referrals. Although they reflected that it was positive that there was such a range of referral organisations and activities within the scheme, they stated that sometimes Service users get confused who is who, what service you are there to deliver, and how the range of services are supposed to link together.

Risk of duplication or missing opportunities

One of the challenges raised by two respondents was that as a referral organisation, you are only delivering one aspect of what can be a fairly complex series of referrals. Although both said the information provided by VAR advisors is very useful in terms of understanding where else Service users have been referred to, they pointed to the risk of duplication or missing opportunities, believing aspects are being picked up elsewhere.

Volunteers

As this is a service built around volunteers, the ongoing challenge is recruiting enough volunteers to match the referrals. The service couldn't operate without the dedication of volunteers. Although recruiting, training and supervising volunteers is a very time consuming process, the British Red Cross has a duty of care to train volunteers to the same quality standards as staff. This does pose challenges for the service.

Measuring impact

One respondent referred to the challenge of measuring the impact of the service. They measure success currently based on the Service user's top three goals, considering how they have progressed against a goal since the point of referral. However, one respondent talked about the difficulty of quantifying some of the impacts, and it was suggested that the descriptive case studies that they provide each month are more illustrative of the complex range of outcomes being achieved by individual Service users.

Encouraging people to engage

Staff reflected on the challenge of encouraging some people to engage when they are really struggling to motivate themselves:

> "*They don't always want to engage with you. We do try, and we'll try several times, and we keep feeding back to VAR, so that's a challenge.*" (Staff)

Finances

It was suggested that the funding was very tight for the service, which does constrain the work that can be done. An example of this is always being aware of volunteer expenses, which is difficult because it is a service which relies on volunteers. However, it was understood that this reflected the limitations of the budget overall.

Case Study 2: Active Regen

The organisation

Active Regen is a non-profit organisation which aims to support people to develop healthier lifestyles through delivering physical activity and sports programmes. As well as supporting people to take part in healthy activities, Active Regen aims to engage people in volunteering through sports, including coaching and refereeing. The organisation seeks to support people to become healthier and develop skills, and engages people from the age of 5 years upwards.

Services provided through Social Prescribing

Within Rotherham, Active Regen delivers 3 sessions per week which engage people in social and physical activities. The activities range from the more physical, such as X-box games and team activities such as curling, to social activities such as regular quizzes.

The sessions have been evolving since the beginning, in order to reflect the preferences and needs of those attending. The flexible nature of the activities has enabled coaches to provide opportunities for Service users to learn about new activities, and find out whether they like them. People attending are able to request activities and the coaches respond by planning new activities into future sessions.

Successes

The interviews highlighted a number of successes for Social Prescribing Service users, which are summarised below:

Reducing social isolation

The Service users talked a great deal about the social side of the Active Regen activity sessions. They suggested that getting to meet you people and socialise is a key benefit to the sessions. Once people have tried the activities, they tend to keep coming back. The sessions are very sociable, and people form friendships. Service users often go from doing no activities, to getting involved in a number of different sessions.

Service users also spoke very highly of the individual staff members that run the sessions, demonstrating the importance of the rapport between staff and Service users. Building rapport and relationships was raised as an important factor in the success of the sessions for individuals, and it was clear from interviews with Service users that their views of staff was important in the longevity of their attendance. As many of the people being referred into the Active Regen sessions are older people, and the coaches are young, the intergenerational nature of the sessions has been an unexpected success. Both clearly gain from spending time working with people from other generations.

Active Regen staff members stated that the sessions had succeeded in reducing isolation, as many people attending have made friends through the sessions. Service users have reported being more active and feeling more confident, providing feedback verbally and via questionnaires. Staff running the sessions have noted that people often start the sessions quite shy and reserved, but within just a couple of weeks, they become more outgoing, and even quite competitive within the sessions.

In a small number of cases, people who have been referred onto one of Active Regen's activities have started volunteering within the organisation.

Supporting carers

Active Regen encourages carers and relatives to come along to the sessions, either to help or to get involved in the activities themselves. They find that many carers are in a similar boat to the Service users, such as feeling isolated. Coming along to the session also enables carers to meet other people in similar situations.

Interviewees also reflected on a key benefit of the Social Prescribing Service: the development of links with other organisations in the area.

Links with other organisations

An important success has been the positive links made with other organisations involved in the social prescribing service. Active Regen now has stronger relationships with other services, but also has developed better links with libraries, health services and carers organisations. Staff described how these stronger relationships have led to more cross-referrals, as they are able to encourage Service users to attend a range of different activities within their community. They envisage that instances of cross-referring will increase as the service continues.

As well as the successes of the service, those who took part in interviews were asked about any challenges they felt the service faced. These are summarised below.

Challenges

Transport

A key challenge for people attending the Active Regen sessions is the cost of transport. When speaking to some Service users attending one of the weekly sessions, the cost of travelling to and from the session by community transport was prohibitive.

> "*It was free transport, but now it costs too much door-to-door.*"

Although the organisation does make all the arrangements for Service users wishing to travel this way, they suggest that many people are deterred by the cost.

Getting people to the first session

Getting Service users to their first session can be one of the biggest challenges, because people are daunted by a new group, but also because of the physical activities involved. As one member of staff reflected:

> *"Getting the patient to the first session, if they're isolated, it's scary at first. But after the first session, people come back."* (Staff)

The organisation has tried to tackle this challenge in two key ways. The first is to encourage carers or relatives to attend with Service users. The second is to conduct home visits, to meet those who have been referred, and encourage them to come along. When people do make it to a session, they tend to keep coming back.

Attendance

Although attendance at two sessions is high and increasing, attendance at the third session is sometimes low. It was suggested that this may be because of transport costs, but also because they are relying on referrals. Those who were already attending this session expressed surprise that more people didn't attend. Linked to this are the problems caused by an unexpected incident such as a fall or an illness. If people are prevented from coming

for whatever reason, then they can sometimes get out of the routine of attending. In such instances, it's hard to know how to tackle this.

Sustainability

Active Regen are concerned about the implications if funding ceases, so are actively looking at longer-term sustainable funding options.

Service user interviews

Mrs A

Mrs A has been attending the Active Regen sessions for over a year, having been referred by her GP practice. She said that she gets a great deal out of attending:

> "*I love it. I really miss it if I can't come.*" (Mrs A)

Her carer brings her along to the session, which she said does sometimes present a problem if her carer cannot bring her. She is extremely positive about the session, and suggested it was disappointing that this particular session was not better attended:

> "*People don't realise what they've got. It's such a shame - I've never met anyone outside the group who's heard of it.*" (Mrs A)

Mrs A was very complimentary about the staff that run the activity sessions, stating:

> "*It wouldn't be the same without them. They're very nice - couldn't be better.*" (Mrs A)

Mr B

Mr B has been coming to the session for almost a year, and suggested that, as well as the physical benefits, there is a real value in the social side of coming along to the Active Regen session:

> "*It keeps you going. It gets you out of the house. A lot of us live on our own, so it gets us out. Otherwise we'd be stuck at home*." (Mr B)

Mr B is still physically able, and still drives, so has started collecting two or three other attendees who live close by. He raised the issue of transport, suggesting it is a real barrier to greater attendance because of the cost of community transport. He suggested that it would be useful if a volunteer driver scheme was introduced (much like schemes supporting hospital appointments in certain areas). He said it would cut the costs of attending and cover the cost of those willing to drive.

Mr B said that as well as physical benefits, the session helps people to exercise the brain, through learning new skills, taking part in the weekly quiz, and through meeting new people:

> "*You meet new people - it helps with conversation.*" (Mr B)

Mrs C

Mrs C has been coming along to the Active Regen session for a couple of months. She was very positive about the session, and was particularly complimentary of the range of activities which the group offered. She usually travels to the session on a mobility scooter, which does present problems when the weather is bad. Mr B had been able to collect Mrs C on the day of the session, enabling her to attend despite the poor weather. She suggested that the cost of public transport would prevent her from being able to attend, suggesting it is almost £4 each way to get to the session, despite living only a short distance from the venue.

Mr D

Mr D has been coming to the session for almost a year. He is able to travel to and from the session with Mr B, which he suggested does help a great deal, as the transport costs would be a problem for him. He was very positive about the range of activities available, suggesting that there is always something new to try:

> "*You get to have a chat, try something new. You learn new skills, or have a go at reviving old ones anyway*." (Mr D)

Case Study 3: South Yorkshire Centre for Inclusive Living

The organisation

South Yorkshire Centre for Inclusive Living (SYCIL) is a charity which works to support people to live independently. Services include advocacy, information and advice, independent living support, occupational therapy and physiotherapy, training and peer support.

Services provided through Social Prescribing

SYCIL provides three services within the Social Prescribing Service:

- a befriending/enabling service - working with people one-to-one helping people to develop confidence to get out and about, access services, confidence to travel
- a peer support group - providing a time and a space for people to come along, meet, create social opportunities
- advice and information - mainly around welfare benefits.

Successes

The interviews highlighted a number of successes for Social Prescribing Service users which are summarised below:

Reduced social isolation

Staff from SYCIL described the ways in which their services were helping people to feel less isolated, through enabling people to engage in activities from visiting the supermarket to providing practical advice about feeling safer and less isolated in their communities. Staff described how enabling Service users to attend groups has enabled firm social ties to develop. A significant example of this was a social group session that SYCIL ran as a means of supporting people. This group has proved so successful that group members have been supported by both SYCIL and VAR to establish as an independent group. The mainstreaming of this group has not only led to its sustainability, but has also enabled SYCIL to start work on establishing a different kind of support drop-in session.

Increased independence

Staff also explained how services were enabling Service users to become more independent, developing the confidence to engage in new activities. One staff member explained how a Service user she'd been working with had decided to join a new group:

> "*The support starts off quite intensive, and then eases off, and she's virtually reached the end of it. But I think for her to, she's started using her own initiative on things as well. There was a speaker to one of the groups that she came to and then she took herself of do a course they were promoting.*" (Staff)

A second member of staff described how supporting Service users to travel independently and attend new groups had enabled them to make new friendships, grow their social networks and live in a better way. In some cases, people had not travelled independently for many years, and this service was the first which had enabled them to start to tackle the barriers they were facing.

Access to wider welfare benefits

One staff member talked about the work being done to support Service users in accessing a range of welfare benefits to which they are entitled. Advice and support was helping Service

users to understand their situation, and practical support was being provided to help Service users to complete applications. This staff member explained that she was often helping people who wouldn't necessarily visit advice centres, or sought help previously:

> "*Often it was people who didn't know anything about benefits, and probably wouldn't consider going to benefits offices or advice centres. So to some extent I think the referral system has tapped a new source of claimant, because a lot of the, certainly a lot of the benefits I deal with aren't means tested, you know, a lot of disability benefits, AA, DLA tend not to means test, and a lot of people, perhaps older people especially think 'I've got money in the bank, or I've got income, I won't qualify.*" (Staff)

The Social Prescribing model

Staff also reflected on how they felt the Social Prescribing Service itself was a positive model and intervention. These reflections are summarised below:

Relationships with other services/organisations

Cross referrals are taking place, so groups are working well with each other, becoming more aware of other groups working within the area. The project has enabled SYCIL to become more aware of other services in the area, which will have positive outcomes for future work. Staff referred to the positive opportunities they have to meet other service providers.

As well as the other service providers, SYCIL staff talked positively about the relationship they have with VAR advisors, and how skilled and responsive the advisors are.

> "*The VAR advisors are very skilled. Passing back to them for advice at any point is good.*" (Staff)

Working imaginatively

Staff talked about the way in which they had to develop creative ways of working with different Service users in order to try to help them to achieve their goals. Staff referred to the way in which this work enabled them to work imaginatively with Service users, in order to meet very individual needs. Although there were challenges discussed, particularly in terms of time constraints, staff reflected on the positive responses received from Service users.

The Social Prescribing way of working

Staff within SYCIL reflected positively on the Social Prescribing model:

> *"I think the social prescribing model in Rotherham is fantastic… I think the way that agencies, there's a lot of interagency working. And it appears that a lot of voluntary agencies are pulling together, and creating a really strong network."* (Staff)

> *"The social prescribing model would definitely be a good model to be rolled out, just because there's so much continuity of care. I think that, I would like to think that if I was an older person, and I went to my doctor and said that I was feeling anxious or depressed, that an advisor come out and support me to set up some services. Because there is so much isolation amongst the elderly… I don't think I've seen such a good scheme of linking people to services."* (Staff).

Staff reflected on the quality of the referrals received from VAR, and how the level of detail really helped referral organisations.

As well as the successes of the service, interviewees were asked about any challenges they felt the service faced. These are summarised below.

Challenges

Short-term nature of the contract

The short-term nature of the social prescribing contract combined with late contract renewal led to one member of staff leaving to get another job. The change in personnel was a challenge for many Service users - particularly when working with older people, they build trust and relationships with staff, and when staff change this can undermine the positive outcomes achieved:

> "*I think it's about them feeling, you know, safe and feeling that they know who's coming to visit them and they know what their agenda is.*" (Staff)

Contract negotiations were still ongoing beyond the end of the last contract, so there is a lack of job security for staff. This also poses a problem with continuity/work planning.

Risk of duplication

As SYCIL staff have to conduct their own assessment when they first receive the referral, there is a risk that the Service user experiences duplication between their experience of the meeting with the VAR advisor and their first meeting with SYCIL. It is difficult to know how this can be improved, as all organisations need the relevant information.

Linked to this is that some Service users report to feeling overwhelmed by the range of support/providers. There are often many different services involved in one person's referral so they are then contacted by numerous services about separate issues which means that some Service users get confused about what they are receiving from whom.

Linked to this is that the provider organisations all get copies of the referral - which just include very brief notes about who's being referred and for what. Concerned that there could easily be overlapping and thus duplication between services, as once they start working with the Service user, lines get blurred between who is doing what.

Short-term contact with Service user

One challenge is that the fairly short-term nature of the intervention means that staff members are not always able to see the outcome for the person they have worked with. This differs from other models of working, where a worker would keep a case 'open' until outcomes had been achieved.

The short-term nature of the service did lead some staff to find ways of supporting Service users beyond the referral. This was usually in the form of quick emails or phone calls to check on the outcomes of a particular referral, to provide a bit of motivation or simply to provide positive feedback on ongoing achievements. One respondent explained the reasoning behind this:

> "*we all like affirmation, don't we? And when someone's worked so hard and achieved so much… It's important to keep that very, very basic contact with somebody, and then gradually lessen it over the weeks.*" (Staff).

Referring younger people

As most of the Service users referred are older people, there was a query about how younger people with LTCs are referred on. As referring takes place at the discretion of the GP it is unclear how effective the process is for all.

Service user interviews

Mrs A

Mrs A had first been referred to SYCIL following a 7 day stay in hospital because of a TIA (Transient Ischemic Attack), which caused the loss of sight in one eye. Mrs A had also suffered a series of strokes in previous years. She reflected on the difficult period of time leading up to her illness, when she was caring for her husband, who was terminally ill:

> "*I'm not surprised that all this has happened to me since, because it's brought me down to nothing. Mentally as well.*" (Mrs A)

When out of hospital, Mrs A described how she had felt very low and lacking in energy:

> "*It's a downward spiral when you've had strokes because you lose your energy levels, it blows your mind. And you feel completely useless*." (Mrs A)

Mrs A was contacted by a member of staff at SYCIL, who took her to her first SYCIL meeting. She is receiving support from one member of staff who is enabling Mrs A to gain the confidence to start to attend groups (such as a neurological group run by the Stroke Association) without assistance. Mrs A describes this process of starting to do things independently as challenging but she is persevering.

Mrs A talked about how much she values the staff member at SYCIL that she has been working with:

> "*It's as though I've known her a million years… She's got the ability to make me feel special. And before [she] came I was like a, well a car with a flat tyre. I was getting nowhere very fast*."

Mrs A reflected on her feelings of relative isolation before starting to work with SYCIL:

> "*Everybody else's life was steaming ahead so all my three children were living the same life, and my life had altered completely. And if they did bring euthanasia in, but they've just voted no against it, but some mornings I would probably have took a bit of, not persuading to go, but thinking I ought to do. I didn't feel like dying, but I didn't feel like living either. So [SYCIL staff member] came along, and I couldn't open my heart to anyone, except I could open my heart to [SYCIL staff member] through responding to what she was telling me, and making me a more positive person. Because she had this ability to make me feel as if I was worthwhile.*"

Mrs A talked about how she was starting to feel more like herself again, and grow in confidence, and how she attributes this to the support she is receiving from SYCIL:

> "*She's now got me to the stage where I'm climbing back up to being [myself] who was, who could tell the doctor off.*"

And:

> "*She didn't just offer me the things, she actually took me there, and included me. And then she said, look, I want you to start trying, reaching out and going on the one-to-one bus, she booked me into the one-to-one to the neurological group at the Stroke Association.*"

The support that Mrs A has been receiving through the Social Prescribing Service is enabling her to access new services and build new relationships, and the work that SYCIL staff are doing is central to this.

Appendix 2: Overview of funded social prescribing services in Rotherham

A2

Services Provided 2014-15

Service area	Organisation/group	Individual or group service	Who for	Frequency	Service detail	Dates service active
Advice and Information	Age UK	Individual	All SPS-referred Service users aged 55+	Ongoing service	Mainly home visits for welfare benefits advice. Up to one 2-hour visit or telephone support per Service user	Apr 14-Nov 14
Advice and Information	Citizen's Advice Bureau	Individual	All SPS-referred Service users	Ongoing services	Mainly home visits for welfare benefits advice. Up to one 2-hour visit or telephone support per Service user	Apr 14-Nov 14
Advice and Information	South Yorkshire Centre for Inclusive Living	Individual	All SPS-referred Service users	Ongoing service	Mainly home visits for welfare benefits advice. Up to one 2-hour visit or telephone support per Service user	Apr 14-Nov 14
Advocacy & Support	Active Independence	Individual	All SPS-referred Service users	Ongoing service	Advocacy and support service on behalf of Service users who need help accessing social care packages/are turned down/package reduced and want to challenge it or need help to set up the most suitable package. 15 hours support per Service user	Apr 14-Sep 14
Advocacy & Support	South Yorkshire Centre for Inclusive Living (not SPS funded)	Individual	All SPS-referred Service users	Ongoing service	Advocacy and support service on behalf of Service users who need help accessing social care packages/direct payments/housing/blue badge/adaptations, etc.	Apr 14-Sep 14

Advocacy & Support	Tassibee	Individual	BME women	Ongoing service	Advocacy & Support for BME women and men. 1-to-1 emotional/practical support in the home and enabling Service users to access community social activities. Delivered by peer advocates with advocacy support to enable access to health services and social care packages. 15 hours support per Service user	Apr 14-Sep 14
Advocacy & Support	YAWR Services	Individual	All SPS Service users	Ongoing service	Advocacy & Support. 1-to-1 emotional/practical support in the home and enabling Service users to access community social activities. Delivered by peer advocates with advocacy support to enable access to health services and social care packages. 15 hours support per Service user	Apr 14-Sep 14
Befriending Plus	Age UK	Individual	All SPS-referred Service users aged 55+	Ongoing services	Home-based 1-to-1 practical and emotional support/support to get out and about / help to access community services/companionship. 10 visits per Service user	Apr 14-Nov 14
Befriending Plus	British Red Cross	Individual	All SPS-referred Service users	Ongoing service	Service users assessment followed by allocation to trained volunteer befriender. Goal orientated service with volunteer befriending support per Service user. Enables independence in the home and encourages community participation. 10 weeks *2 hours per Service user	Apr 14-Dec 14
Befriending Plus	Royal Voluntary Service	Individual	All SPS-referred Service users	Ongoing service	Minimum offer includes befriending in the home, escorting to appointments, etc., shopping on behalf of or with, linking people to community activities, transporting Service users. 10 weeks *2 hours per Service user	Apr 14-Dec 14
Befriending Plus	South Yorkshire Centre for Inclusive Living	Individual	SPS-referred Service users working towards independent living	Ongoing service	1-to-1 Support Worker service to enable Service users to live a more independent life. Includes home visit/s and accompanying Service users to appointments, shopping trips, social events and activities, etc. Also help to access other statutory services. 15 Hours support per Service user	Apr 14-Dec 14

Befriending Plus with Home Exercise	Rotherham United Community Sports Trust	Individual	All SPS-referred Service users	Weekly	Companionship and help improve mobility/flexibility through gentle exercise. Up to 10 weekly home visits per Service user. 2 hours per visit	Apr 14-Sep 14
Community Engagement Group	Active Regen	Group	All SPS-referred Service users	Weekly	3 community-based programmes (Maltby; Kiveton Park, East Herringthorpe) include (1) strength and balance, (2) Virtual to Reality activities (e.g. X Box, Wii), (3) Walking for beginners, (4) Boccia programme. . 10 weeks per Service user	May 14-Sep 14
Community Engagement Group	Rotherham United Community Sports Trust	Group	All SPS-referred Service users	Weekly	2 community social and activity sessions to be delivered in Dinnington and Swinton. 10 weeks per Service user. £4.50 plus transport	Apr 14-Sep 14
Community Engagement Group	South Yorkshire Centre for Inclusive Living	Group	All SPS-referred Service users	Weekly	Monthly social group session in Wickersley Community Centre April-June 2014. From July onwards Group will continue to meet weekly for coffee morning sessions at SYCIL offices in Rotherham. Groups facilitated by SYCIL Project Co-ordinator.	Apr 14-Dec 14
Community Engagement Group	Titans Community Foundation	Group	All SPS-referred Service users	Weekly	Weekly group activities at Clifton Lane Sports Ground 10.00 - 1.00 every Wednesday including light exercise, social activities (games, entertainment, tea and biscuits). £5.00 plus transport	Apr 14-Nov 14
Community Engagement Group	Titans Community Foundation (not SPS Funded)	Group	Self-funding Group	Weekly	Weekly group activities at Clifton Lane Sports Ground 10am-1pm every Tuesday including light exercise, social activities (games, entertainment, tea and biscuits). £15.00 per weekly session plus transport. Total cost with transport will not exceed £20.00	Apr 14-onwards

Community Engagement Group	YAWR Services	Group	All SPS Service users	Weekly	Group activity sessions targeted at women from the BME community. Weekly activities include Active Always physical activities/gardening, massage/complementary therapies, arts & crafts and knitting. Speakers from health, social care and public services attend the sessions. 10 weeks per Service user	Apr 14-Sep 14
Community Engagement Group - Asian males 50+	Unity Centre	Group	Men aged 50+ from Yemeni, Pakistani and other BME communities	Weekly	Group support for Asian men aged 50+ from BME communities, particularly Yemeni and Pakistani. Includes life stories/memories, exercise sessions, information sessions, end of project trip.	Apr 14-Sep 14
Community Engagement Group - Fit For the Future	Age UK (not funded by SPS)	Group	All adults aged 55+	Ongoing service	Fit For the Future activity sessions held in a variety of community venues Throughout the borough. Sessions facilitated for 10 weeks then volunteer-led	Jan 14-Mar 15
Community Engagement Group - Reminiscence group	Elmet Archaeological Services Ltd, Wath	Group	Service users with dementia and their carers or any Service users experiencing social isolation (those living in Wath and surrounding area prioritised)	Weekly	Facilitated interactive reminiscence sessions delivered at Wath Trinity Community Hall on Tuesday mornings from June 2014 10.30am-12pm. Memory boxes, music, artefacts, social interaction. 10 weeks per Service user	Apr 14-Nov 14
Community Engagement Group - Tai Chi	Surehealth	Group	All SPS Service users including people with dementia and carers	Weekly	Weekly Tai Chi classes take place at Edward Dunn Memorial Hall, Maltby, Montgomery Hall, Wath and Rotherham Civic Theatre Annex. Carers welcome to attend. Free taster sessions also available in community venues	Apr 14-Sep 14

Community Hub	High Street Centre, Rawmarsh	Individual	All SPS-referred Service users (those living in Rawmarsh and surrounding area prioritised)	Ongoing service	Activities Co-ordinator introduces Service users to activities in High Street Centre. Volunteer befrienders accompany Service users to activities of their choice. New activities including a luncheon club set up in the Centre to meet Service user needs where required. Activities Co-ordinator arranges transport for Service users where required. SPS-only Service users Luncheon club starts 2nd June 12-2pm £3.50 per person.	Apr 14-Mar 15
Community Hub	Montgomery Hall, Wath	Individual	All SPS-referred Service users (those living in Wath and surrounding area prioritised)	Ongoing service	Activities Co-ordinator introduces Service users to activities in Montgomery Hall. Co-ordinator refers Service users to activities in Montgomery Hall and the wider community. New activities/groups to meet needs of Service users. Trained volunteer befrienders transport Service users to Montgomery Hall. Activities Co-ordinator arranges transport for Service users if required.	Apr 14-Mar 15
Community Hub Plus	Kimberworth Park Community Partnership	Individual	SPS-referred Service users living in or around Kimberworth Park	Ongoing service	SPS referrals direct to KPCP Project Co-ordinator for home visit and referral to local neighbourhood services: Community gym, gardening project, financial inclusion support, massage/pamper sessions, fitness groups, social groups, employment advice	Apr 14-Mar 15
Dementia Support Worker Service	Alzheimer's Society	Individual	SPS-referred Service users with dementia and their carers	Ongoing service	Initial 1-to-1 assessment/signposting and support service. Ongoing advice and practical support. Support to attend dementia cafes/other groups. Hours of support are flexible depending on need	Apr 14-Dec 14
Dementia Volunteer Befriending service	Alzheimer's Society (not funded by SPS)	Individual	All dementia Service users and their carers	Ongoing service	Volunteer befriending service providing companionship & emotional support; support to continue hobbies and personal interests; facilitate opportunities to participate in leisure and social activities; support with regular activities e.g. shopping; providing a break for carers	Apr 14 onwards

Flexible carer respite service with additional services	Crossroads Care	Individual	Carers of SPS Service users with LTCs	Ongoing service	Carer assessment; Up to 30 hours flexible respite; stress reduction for carers (complementary therapies); carer training; peer support group	Apr 14-Mar 15
Sensory Group	Sense	Group	All SPS Service users with vision and/or hearing impairment	Weekly	Sessions delivered 10am-1pm on Fridays from April 2014. Textiles, pottery, music, storytelling. Sessions delivered at Ashley Court Resource Centre, Rawmarsh Road, Rotherham. First 3 weeks free then £3.50 per week plus transport. 16 weeks per Service user	Jul 13-Mar 14
Subsidised fares for SPS	Rotherham Community Transport	n/a	All SPS-referred Service users	Ongoing service	Subsidised fares for Service users to travel to group activities funded by the Social Prescribing Service. Costs per individual journey: Up to 2 miles £2.60; 3-4 miles £3.00; 5-6 miles £3.40; 7-8 miles £3.80	Apr 14-Mar 15
Therapeutic Services	Satori Community Counselling	Individual	All SPS-referred Service users	Ongoing service	1-to-1 counselling at RAIN building or in Service user's home. 6-8 fortnightly sessions.	Apr 14-Sep 14
Therapeutic Services	Universal Embrace	Group	All SPS-referred Service users	Weekly	Complementary therapy and social group sessions/trained volunteers deliver this service. Sessions take place at Edward Dunn Memorial Hall, Maltby on Tuesdays from 1-5pm.	Apr 14-Sep 14

Services Provided 2015-16

Service area	Organisation/group	Individual or group service	Who for	Frequency	Service detail	Dates service active
Advice and Information	Age UK	Individual	All SPS-referred Service users aged 55+	Ongoing service	Mainly home visits for welfare benefits advice and support with forms, etc. Home visit or telephone support per Service user	Apr 15-Mar 16
Advice and Information	Citizen's Advice Bureau	Individual	All SPS-referred Service users	Ongoing service	Mainly home visits for welfare benefits advice and support with forms, etc. Home visit or telephone support per Service user. Includes debt advice.	Apr 15-Mar 16
Advice and Information	South Yorkshire Centre for Inclusive Living	Individual	All SPS-referred Service users	Ongoing service	Mainly home visits for welfare benefits advice and support with forms, etc. Home visit or telephone support per Service user	Apr 15-Mar 16
Advocacy & Support	Active Independence	Individual	All SPS-referred Service users	Ongoing service	Disability-led advocacy and support service for people who need help accessing social care packages/are turned down/package reduced and want to challenge it or need help to set up the most suitable package. Complex welfare benefits advocacy through to tribunal. Average of 15 hours' support per Service user	Apr 15-Mar 16
Advocacy & Support	YAWR Services	Individual	All SPS Service users	Ongoing service	Advocacy & Support. 1-to-1 emotional/practical support in the home and enabling Service users to access community activities. Delivered by peer advocates with advocacy support to enable access to health services and social care packages. 15 hours support per Service user	Apr 15-Mar 16
Befriending Plus	Age UK	Individual	All SPS-referred Service users aged 55+	Ongoing services	Patient assessment followed by home-based 1-to-1 practical and emotional support/support to get out and about/help to access community services/companionship. 15 hours' delivery time per Service user	Apr 15-Mar 16

Befriending Plus	British Red Cross	Individual	All SPS-referred Service users	Ongoing service	Service user assessment followed by allocation to trained volunteer befriender who visits Service users at home. Goal orientated service with volunteer befriending support per Service user. Enables independence in the home and encourages community participation. 15 hours' delivery time per Service user	Apr 15-Mar 16
Befriending Plus	Royal Voluntary Service	Individual	All SPS-referred Service users aged 50+	Ongoing service	Service user assessment followed by befriending in the home, escorting to appointments, etc,, shopping on behalf of or with, linking people to community activities, transporting Service users. 15 hours' delivery time per Service user	Apr 15-Mar 16
Befriending Plus	South Yorkshire Centre for Inclusive Living	Individual	SPS-referred Service users working towards independent living	Ongoing service	1-to-1 Support Worker service to enable Service users to live a more independent life. Includes home visit/s and accompanying Service users to appointments, shopping trips, social events and activities, etc. Also help to access other statutory services. 15 hours' delivery time per Service user	Apr 15-Mar 16
Carer Support Service	Crossroads Care	Individual	Carers of SPS Service users	Ongoing service	Carer assessment followed by up to 30 hours' flexible respite.	Apr 15-Mar 16
Community Engagement Group	Active Regen	Group	All SPS-referred Service users	Weekly	3 community-based programmes (Maltby; Kiveton Park, East Herringthorpe) include (1) strength and balance, (2) Virtual to Reality activities (e.g. X Box, Wii), (3) Boccia programme. 12 weeks' delivery per Service user	Apr 15-Sep 15
Community Engagement Group	South Yorkshire Centre for Inclusive Living	Group	All SPS-referred Service users	Weekly	Monthly social group session at Wickersley Community Centre. The group meets weekly for coffee morning and social activities. The group is facilitated by SYCIL's Project Co-ordinator.	Apr 15-Mar 16

Community Engagement Group (Sensory Group)	Sense	Group	All SPS Service users with vision and/or hearing impairment	Weekly	Sensory Craft Group. Sessions delivered 10.00-1.00 on Wednesdays Thursdays and Fridays from April 2015. Textiles, pottery, music, storytelling. Sessions delivered at Ashley Court Resource Centre, Rawmarsh Road, Rotherham. First 3 weeks free then £3.50 per week plus transport. 16 weeks per Service user. Friday group only funded by SPS.	Apr 15-Mar 16
Community Hub	Dinnington Area Regeneration Trust	Individual	All SPS-referred Service users (those living in Dinnington and surrounding area prioritised)	Ongoing service	An Activities and Group Development Co-ordinator contacts and supports Service users to meet with them at Middleton Hall. Practical support is offered to help the Service user to attend the first meeting (e.g. transport). The Co-ordinator spends up to 7 hours supporting Service users to access activities/groups in Middleton Hall and the wider community. The Co-ordinator also develops new community activities that Service users can access.	Jul 15-Dec 15
Community Hub	Montgomery Hall, Wath	Individual	All SPS-referred Service users (those living in Wath and surrounding area prioritised)	Ongoing service	An Activities and Group Development Co-ordinator contacts and supports Service users to meet with them at Montgomery Hall. Practical support is offered to help the Service user to attend the first meeting (e.g. transport). The Co-ordinator spends up to 7 hours supporting Service users to access activities/groups in Montgomery Hall and the wider community. The Co-ordinator also develops new community activities that Service users can access.	Apr 15-Sep 15
Community Hub Plus	Kimberworth Park Community Partnership	Individual	SPS-referred Service users living in or around Kimberworth Park	Ongoing service	An Activities and Group Development Co-ordinator contacts Service users and visits them at home to assess their social needs and advise them on community services and activities. Practical support is offered to help the Service user to meet the Co-ordinator at the Chislett Centre (e.g. transport). The Co-ordinator spends up to 10 hours supporting Service users to access activities/groups in the Chislett Centre and the wider community. The Co-ordinator also develops new community activities that Service users can access.	Apr 15-Mar 16

Dementia Support Worker Service	Alzheimer's Society	Individual	SPS-referred Service users with dementia and their carers	Ongoing service	The service can be a home visit or telephone support depending on needs of Service user and carer. Initial 1-to-1 assessment/signposting and support service. Ongoing advice and practical support. Support to attend dementia cafes/other groups. Hours of support are flexible depending on need.	Apr 15-Mar 16
Therapeutic Services	Satori Community Counselling	Individual	All SPS-referred Service users	Ongoing service	1-to-1 counselling at RAIN building or in Service user's home. Usually 6-8 sessions per Service user	Apr 15-Sep 15
Therapeutic Services	Radiance & Relaxation	Group	All SPS-referred Service users	Weekly	Group therapy and social group service. Initial home visit from service provider to introduce Service users to therapies and explain service. Following home visit, Service user receives up to 16 weeks' attendance at Therapeutic social and lifestyle group. Group activities include socialising, stress relieving techniques, sleep & relaxation, controlling eating & losing weight, controlling smoking & alcohol, gentle exercise & pain management.	May 15-Oct 15
Therapeutic Services	Rotherham & Barnsley Mind	Individual	All SPS-referred Service users	Ongoing service	1-to-1 counselling at Mind building in Rotherham. Usually 6 sessions per Service user	Mar 15-Sep 15