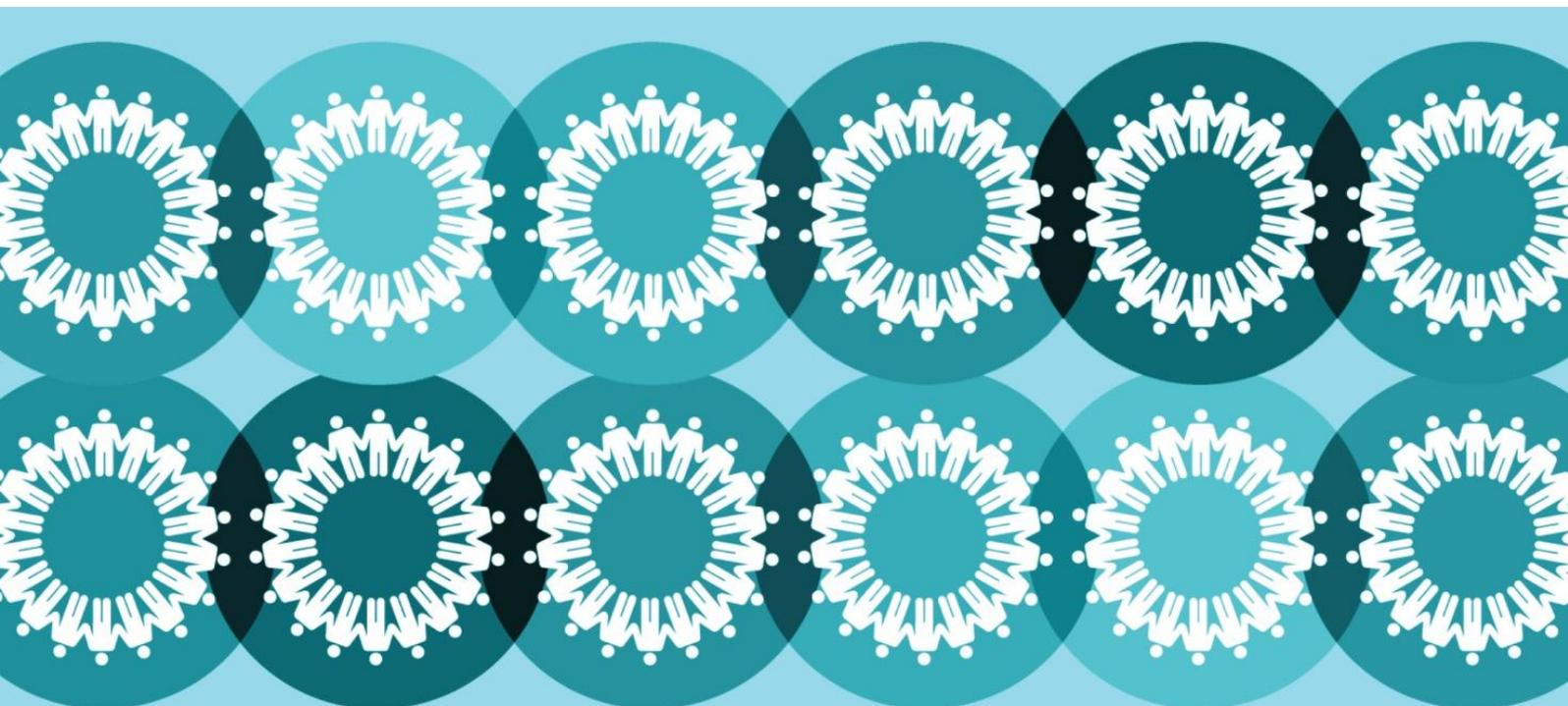


**From dependence to
independence:
*emerging lessons from
the Rotherham Social
Prescribing Pilot***

December 2013



From dependence to independence: emerging lessons from the Rotherham Social Prescribing Pilot

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Contents

Executive Summary	i
1. Introduction	1
2. What is social prescribing?	2
3. Achievements	7
4. Learning from the pilot	14
5. Conclusions and recommendations	24
Appendix 1: Case studies	27
Appendix 2: Overview of funded social prescribing services in Rotherham	32

Executive Summary

Introduction

This is the first report from the independent evaluation of the innovative Rotherham Social Prescribing Pilot being undertaken by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University. The pilot is being delivered by Voluntary Action Rotherham (VAR) on behalf of NHS Rotherham CCG. It runs from April 2012 to March 2014 as part of a wider GP-led Integrated Case Management Pilot and aims to increase the capacity of GP practices to meet the non-clinical needs of their patients with long term conditions (LTCs). The pilot has received around £1m as part of a programme to provide 'additional investment in the community'.

What is social prescribing?

Solutions for improving the health and well-being of people from marginalised and disadvantaged groups that place greater emphasis on preventative interventions have become increasingly common in public policy. Social prescribing commissions services that will prevent worsening health for people with existing LTCs and reduce costly interventions in specialist care. It links patients in primary care and their carers with non-medical sources of support within the community. It is tailor-made for Voluntary and Community Sector (VCS) led interventions and can result in:

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

The Rotherham Social Prescribing Model

The Rotherham Social Prescribing Model is based around a core team consisting of a Project Manager and five Voluntary and Community Sector Advisors (VCSAs) employed by VAR, and a grant programme, which funds additional capacity within the VCS, enabling the development of new community-based services:

- the Project Manager oversees the day-to-day running of the pilot, including management of the grant programme, and acts as a liaison between VCS providers and wider NHS structures.
- VCSAs provide the link between the pilot and multidisciplinary primary care teams. 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.
- through the grant programme **23 VCOs have received grants** with a budgeted total value of £603,000. The grants enable these organisations to deliver a **menu of 33 separate social prescribing services**. These services **act as a gateway** for Social Prescribing patients to access the broader range of services available through the wider VCS.

The pilot 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 a much smaller geographic focus.

What has the Pilot achieved so far?

Referrals

Since September 2012 the pilot has engaged with 28 GP Practices in Rotherham to receive referrals as part of the Case Management Pilot. Overall, **808 referrals were made in the first 12 months** compared to an initial target of 625. It is estimated that around 1,400 patients and carers will have engaged with the service by March 2014.

So far there have been **1,207 onward referrals to VCS services**. Of these 616 have been to services in receipt of direct funding through the pilot and a further 591 have been to services that have not received any funding through the pilot. The types of services most frequently accessed are:

- community based activity (268 referrals, 22 per cent of referrals)
- information and advice (187, 15 per cent)
- befriending (133, 11 per cent)
- community transport (106, nine per cent)

Reducing hospital episodes

The ability of the Pilot to demonstrate impact on patients' need for hospital based services is a key measure of its success. Analysis of hospital episodes has focussed on a cohort of 161 patients for whom data was available for the six months prior to and preceding their SPS referral. The cohort includes clients referred between August and December 2012. Reductions in three types of hospital episodes have been identified compared to the six months prior to referral:

- Accident and Emergency attendances reduced by 21 per cent
- hospital admissions reduced by nine per cent
- outpatient appointments reduced by 29 per cent.

At this stage it is not possible to attribute these changes directly to Social Prescribing but they should be interpreted as positive sign of the potential of the service to have an impact on reducing resources in the longer term.

Social outcomes

Patients' progress towards social outcomes is measured through an 'outcomes star' style tool developed specifically for the service. Initial analysis of this data shows that patients are making positive progress:

- 78 per cent made progress on at least one outcome after six months
- of the outcome categories scoring low (two points or less) at referral, 58 per cent recorded an increase after six months.

What is the learning from the pilot?

Action learning

The ability of the pilot to respond flexibly to the needs of clients and provider organisations has emerged as one of the strengths of the pilot. It is likely that this 'action learning' approach to delivery was enabled by the fact that the service was established as a pilot rather than a mainstream service.

Effectiveness of the Rotherham Social Prescribing model

VCS providers and public sector stakeholders were largely positive about the model of delivery and the role VAR plays in managing the pilot. VAR's understanding of and reach into the VCS across Rotherham means it is uniquely placed to co-ordinate the pilot. However, it was felt that the effectiveness of the pilot was limited by the risk stratification criteria used to determine eligibility for support. By focussing on the most intensive users of health services commissioners were missing an opportunity to achieve a greater number of preventative impacts.

Additionality and added value

The vast majority of VCS activities funded through the pilot are additional. Funding has been used to set-up new services that were not available before and to create additional capacity in existing services. The service has also enabled a number of VCS organisations to provide publicly funded health and social care services for the first time and has created a gateway to wider VCS provision that did not previously exist. This has had the cumulative effect of increasing the overall range, scope and volume of services available to patients with LTCs and their carers.

Public sector stakeholders highlighted the added value provided by the various VCS activities provided through the pilot. In particular they emphasised the benefits for public bodies beyond the CCG as commissioners of the pilot. The local authority, through benefits in the areas of social care and public health, were identified as direct beneficiaries even though they have not funded the pilot.

Outcomes and impact

Although the evidence for this report was collected relatively early on in the pilot a number of examples of outcomes and impact have emerged. These include: patients becoming more independent and able to access social prescribing activities with less intensive support; patients becoming better at managing their long term condition themselves; patients and carers feeling less socially isolated and enjoying more social interaction; and a general improvement in the quality of care available to patients as a result the case management approach. At this stage these provide an illustration of the types of outcomes and impact that might occur more widely as a result of social prescribing in the longer term.

Sustainability and future funding

Interview participants from the VCS and public sectors were asked to consider if, and how, the pilot and the activities it has supported could be sustained if funding for the pilot was not continued beyond March 2014. Respondents were clear that it would be very difficult to sustain the current model without core funding of some sort and withdrawing the services could lead to considerable disbenefits for patients.

Conclusions

1. **The CCG, GP practices and the wider NHS** benefit from the opportunity to refer patients with LTCs to community based services that complement traditional medical interventions. The pilot provides GPs with a gateway to these services and wider VCS provision. There are a number of signs that these interventions could help reduce demand on costly hospital episodes in the longer term.
2. **Other public sector bodies, particularly local authority public health and social care,** benefit from additional services that can be accessed by people with complex needs. Wider preventative benefits are likely to emerge over a longer period. There are strong links between the pilot's achievements and the borough's Health and Well-being Strategy.
3. **People with LTCs and their carers** benefit from an alternative approach to supporting. There is evidence that social prescribing clients are becoming more independent, have experienced a

range of positive outcomes associated with their health and well-being, and are becoming less socially isolated.

4. **Funded VCS providers** have benefited from the opportunity to broaden and diversify their provision for people with complex needs. It has enabled a number of smaller community level providers to engage with health commissioning for the first time, whilst enabling more established providers to test the effectiveness of new and innovative types of provision.

Recommendations

Immediate recommendations

1. Effective communication between VAR and VCS providers, and between VCS providers, is crucial to the ability of the pilot to function effectively. Consideration should be given to how **more frequent face-to-face contact between providers** can be facilitated.
2. The NHS and public sector partners **need to quickly provide a clear message about the future of the service**. The pilot has built up a considerable head of steam over the past 18 months but there is a danger that this could be lost if a decision about re-commissioning is not made soon.

Longer term recommendations

1. The **Pilot should be continued for at least another year**. This will provide sufficient time to identify the longer term outcomes and impacts of the service and provide a degree of financial stability for VCS providers at a time when the wider financial climate in which they are operating is quite volatile.
2. An extension to the pilot would benefit from funding from **the local authority (public health and/or social care) as well as the CCG**. Given the potential preventative benefits and the links to the Health and Well-being Strategy, this might be through the Integration Transformation Fund (ITF).
3. The **funding base of VCS providers could be diversified**. This includes direct payment and individual budget holders purchasing services, and self-funding of certain activities. If there is evidence of public sector resource savings, future social prescribing services could be commissioned through a social impact bond (SIB).
4. The option for the pilot to also **target patients who are less intensive users of health services** should be considered. This would enable a wider range of preventative benefits to be realised, particularly in areas such as mental health and well-being.
5. Future configurations of the Social Prescribing Service should **explore the feasibility of a more flexible referral and assessment model** with a view to assessing the cost efficiency and cost effectiveness of alternative approaches to co-ordinating provision.

Introduction

This report is the first output from the independent evaluation of the innovative Rotherham Social Prescribing Pilot being undertaken by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University. The pilot is being delivered by Voluntary Action Rotherham (VAR) in partnership with more than 30 local voluntary and community organisations (VCOs). It was commissioned by NHS Rotherham in April 2012 as part of a wider GP-led Integrated Case Management Pilot and aims to increase the capacity of GP practices to meet the non-clinical needs of their patients with long term conditions (LTCs), including support for their carers. At its core, the Rotherham Social Prescribing Pilot funds the provision of a voluntary and community sector (VCS) liaison service which:

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

The pilot will run until the end of March 2014, and has received around £1m of funding from NHS Rotherham as part of a programme to provide 'additional recurrent investment in the community' during the transition from the Primary Care Trust (PCT) to the Clinical Commissioning Group (CCG).

1.1. About the evaluation

The evaluation began in June 2013 and will conclude in summer 2014. It has a number of key aims:

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

This interim evaluation report will be followed by a final report in May/June 2014.

1.2. About this report

This interim evaluation report provides the **emerging findings from the pilot** based on the data collected and analysed so far. A final report and full assessment of impact will be published in summer 2014. This report draws on a variety of data sources to reflect on achievements and learning from the activities of the pilot to date:

- analysis of monitoring data collected by VAR
- analysis of hospital episodes data for a cohort of early beneficiaries of the pilot
- in-depth interviews with public sector stakeholders, project staff, and voluntary and community organisations (VCOs) delivering services
- case studies involving service beneficiaries.

The report is divided into the following chapters:

- Chapter 2 provides an introduction to social prescribing
- Chapter 3 provides an overview of the achievements of the pilot to date
- Chapter 4 discusses the learning to have emerged from the pilot so far
- Chapter 5 provides conclusions and recommendations, and outlines next steps for the evaluation
- Appendix 1 provides two detailed case studies of services provided through the pilot
- Appendix 2 provides a summary of all services funded through the pilot.

Some of the data presented in this report provided the basis of a presentation to NHS Rotherham CCG's 'Additional Recurrent Investment in the Community Event' on 16th October 2013 at which commissioners considered the case for continued funding for the Social Prescribing Pilot. The outcome of the re-commissioning process will be known early in 2014.

What is social prescribing?

2

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

2.1. Policy Context

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

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

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

CCGs involve patients and healthcare professionals and operate in partnership with local communities and local authorities. Most CCGs have boundaries that are coterminous with local authorities. They have responsibility for coordinating emergency and urgent care services within their boundaries, and for commissioning services for unregistered patients who live in their area. All GP practices must belong to a clinical commissioning group.

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

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

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

2.2. An introduction to social prescribing

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

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

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

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

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

2.3. Models of social prescribing

Social prescribing interventions can vary enormously, but often include:

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

apprenticeships, support to access community facilities, and community transport

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

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

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

2.4. Evidence in support of social prescribing

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

- improved health and quality of life
- increased patient satisfaction
- fewer primary care consultations
- reduction in visits to outpatients and Accident and Emergency
- decrease in use of hospital resources.

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

2.5. The Rotherham Social Prescribing model

The Rotherham Social Prescribing Pilot was commissioned by NHS Rotherham as part of a GP-led Integrated Case Management Pilot. It 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.¹ Specific support for the carers of case managed patients is also provided. The Pilot has received funding of £1.1 million between April 2012 and March 2014 to provide a voluntary and community sector (VCS) liaison service for the whole borough which:

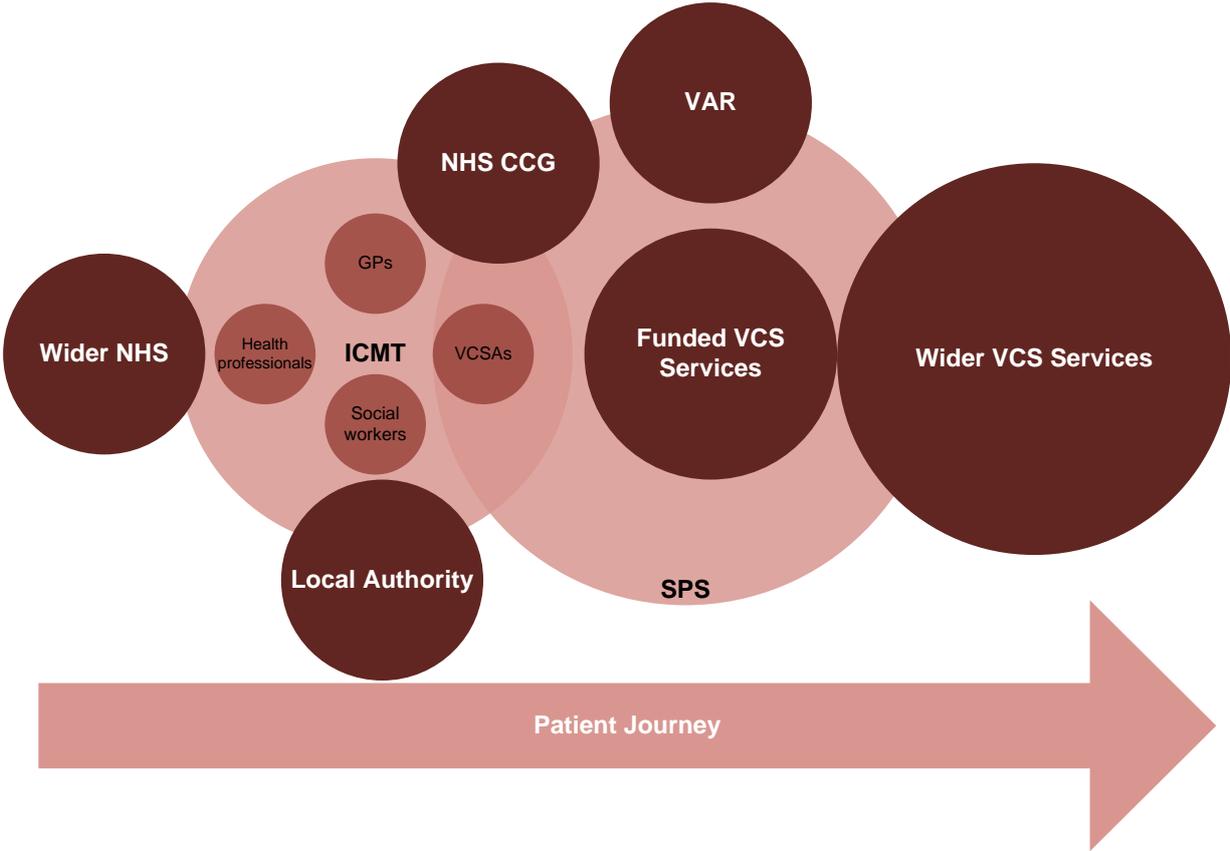
- enables patients and their carers to access support from local VCS organisations
- contributes a VCS perspective to the assessment of needs and care planning for patients referred to multi-disciplinary integrated case management teams (ICMTs)
- funds additional capacity within the VCS, enabling the development of new community-based services.

45 per cent of the funding covers the core cost of developing and running the pilot, with the remaining 55 per cent providing a grant funding pot for a 'menu' of VCS activities. The key components of the service are described below. Diagrammatic representation of the model is provided in figure 2.1 (overleaf).

A core team consisting of a Project Manager and five Voluntary and Community Sector Advisors (VCSAs) is employed by VAR. The Project Manager's role is to oversee the day-to-day running of the pilot, including management of the grant programme, and acting as a liaison between VCS providers and wider NHS structures. The VCSA role provides the link between the pilot 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 patient's needs and discuss the options available to them through social prescribing. VCSAs also form part of the ICMT and attend meetings when social prescribing patients are being discussed.

¹ A risk stratification tool is used to identify the five per cent most intensive users of services: these patients and their carers are eligible for case management and can access social prescribing.

Figure 2.1: The Rotherham Social Prescribing Model



Achievements

This chapter considers the achievements of the Rotherham Social Prescribing Pilot since it commenced in April 2012. It summarises the inception and development process, provides an overview of the different VCS providers commissioned to deliver services through the pilot, highlights referral patterns to date, and discusses the evidence base regarding the impact of the pilot.

3.1. The inception and development process

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

It is also important to recognise the role Voluntary Action Rotherham (VAR) played in setting-up the Social Prescribing Pilot (i.e. prior to it being commissioned). This involved working closely with Rotherham NHS partners to establish the business case for the pilot and developing a model of provision that could be embedded in the Case Management Pilot. VAR also ensured local VCS partners were aware of the proposals for the pilot and were able to provide input at key stages in the development process.

3.2. Voluntary and Community Sector providers

The pilot has commissioned services in two phases. The first phase was in autumn 2012 through which ten VCOs were commissioned to deliver social prescribing services. Some of these services began receiving patients towards the end of 2012 (November/December) but the majority did not commence until January 2013 onwards. The second phase was in spring 2013 through which a further 13 VCOs were commissioned to deliver services. These services began receiving patients from June 2013 onwards. Overall 23 VCOs have received grants to deliver a menu of 33 separate social prescribing services. The budgeted value of these grants, to the end of March 2014, is £603,000. This includes direct grants to the value of £544,000 and a 'floating fund' of £59,000, available for a range of non-grant funded services to be 'spot purchased'. Overall, funding for VCS commissioned services accounts for 55 per cent of the total project budget.

An overview of services provided through the pilot, including the number of referrals to each service (at the end of October 2013), is provided in table 3.1. A more detailed summary is available in Appendix 2.

Table 3.1: Summary of funded social prescribing services in Rotherham

Service provider	Type of service or activity	No of referrals
Active Independence	Peer advocacy with volunteering opportunities	27
Active Regen	Group activity/mobility sessions	34
	Senior peer mentoring - 'Active Friends' buddy scheme	N/A
Age UK	Advice and Information	139
	Reablement service	31
	Befriending service	81
Alzheimer's Society	Dementia Support Worker Service	45
	Dementia Volunteer Befriending service	27
British Red Cross	Volunteer-led befriending and enabling service	34
Crossroads Care	Enabling and support service	79
	Respite service (linked to Carers Looking after Me Course)	Begins Jan 14
Elmet Archaeological Services	Drop-in reminiscence group	10
High Street Centre (Rawmarsh)	Activities Co-ordinator	17
Kimberworth Park Community Partnership	Home visits and referral to community activities	57
Lost Chord	Music sessions for people with dementia (delivered at dementia cafes)	10 sessions (30-50 people per session)
Montgomery Hall (Wath)	Activity Co-ordinator at Montgomery Hall	28
Rotherham Community Transport	Volunteer driver scheme and improved booking and scheduling service	N/A
Rotherham Ethnic Social Care Organisation	Two group activity programmes for BME carers	9
Rotherham United Community Sports Trust	Home Exercise visits	27
	New York Stadium activity sessions	87
	Community based activity sessions	Begins Jan 14

Royal Voluntary Service	Volunteer-led good neighbours befriending and enabling scheme	15
Satori Counselling	One-to-one therapeutic counselling and additional group work sessions	12
Self-Management UK	Caring with Confidence course	13
Sense	Sensory art & craft group sessions	25
South Yorkshire Centre for Inclusive Living	One-to-one Support Worker personal service	82
	Facilitated 'afternoon tea' sessions	50
Surehealth	Community based Tai Chi classes	23
Tassibee	One-to-one peer advocacy and enabling service for BME women	13
Titans Community Foundation	Home visits from Rotherham Titans first team players/Group activities at Clifton Lane Sports Ground	26
Unity Centre	Group activity sessions for Asian men	4
Universal Embrace	Complimentary Therapy and social group sessions	96

3.3. Social prescribing referrals

Referrals-in to social prescribing

Since the pilot became operational in September 2012 it has actively engaged with 28 (out of 36) GP Practices in Rotherham to receive referrals to the service from ICMTs as part of the Case Management Pilot. Overall, 808 referrals were made in the first 12 months compared to an initial target of 625. Based on current referral patterns, it is estimated that around 1,400 patients and carers will have engaged with the service by the time the pilot concludes in March 2014.

So far, the vast majority of referrals have been of patients in the older age groups:

- 66 per cent were aged 75 and over
- 38 per cent were aged 85 and over
- only 11 per cent were aged under 60.

However, there are some signs that younger people are being referred to the service, particularly as ICMTs move down the risk register to identify suitable beneficiaries: since March 2013 there has been a four per cent increase in the number of referrals from the 60-70 age group. Other process measures highlight the vulnerable nature of the Social Prescribing client group: 42 per cent live alone and 37 per cent have an informal carer.

To date, referrals of individuals from black and minority ethnic (BME) communities have been comparably low, accounting for only five per cent of patients. In light of this, the service team have taken a number of steps to understand the social and

cultural barriers to accessing the service as it was originally configured. This work is on-going, but the second phase of grants has resulted in the provision of a number of services from BME-led VCOs, with a view to increasing engagement with patients from BME communities.

Referrals-out to VCS services

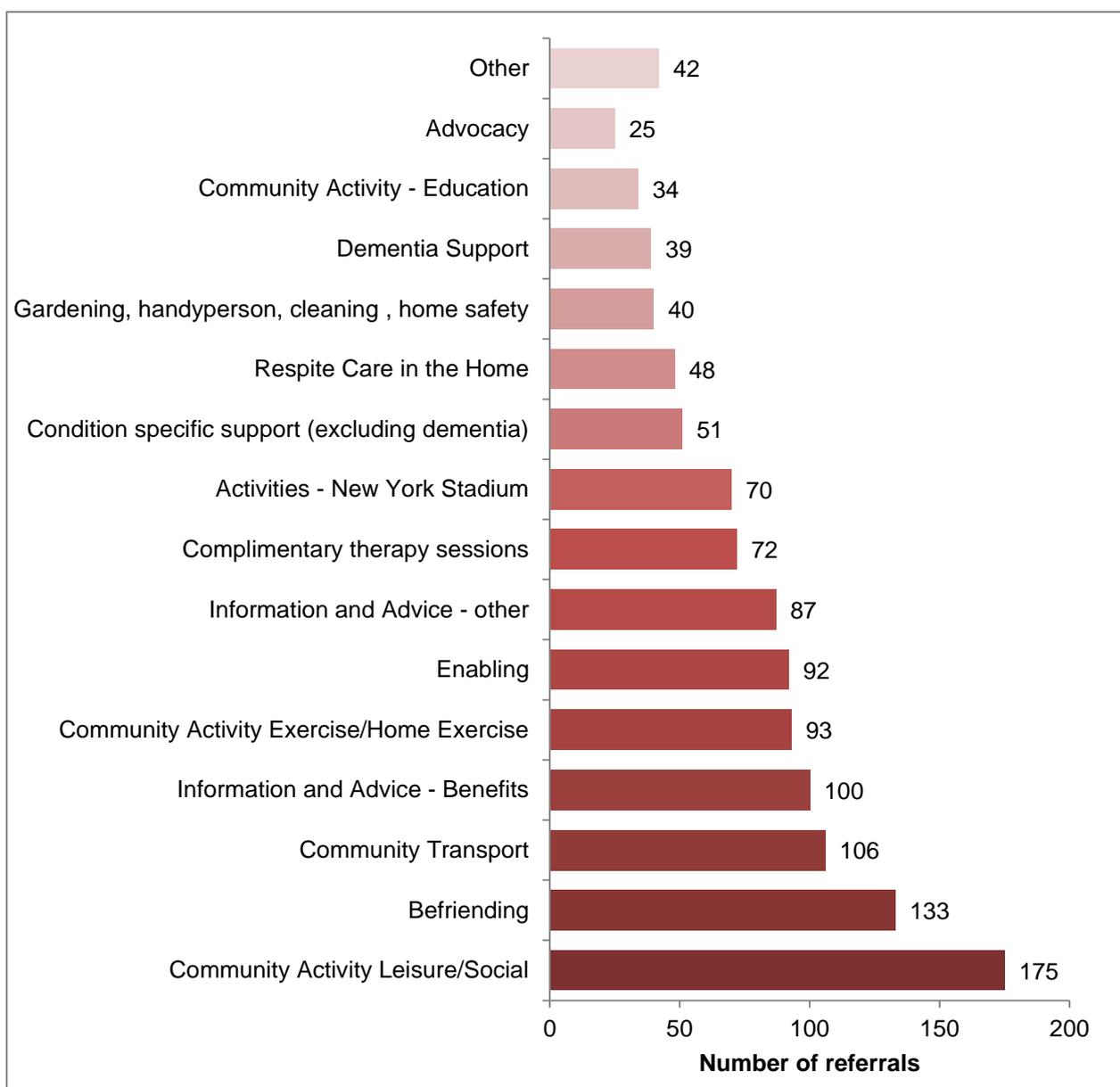
Since the pilot commenced there have been 1,207 onward referrals to VCS services. Of these referrals 616 have been to services or activities in receipt of direct funding through the pilot and a further 591 to services or activities that have not received any funding through this project. These services are predominantly provided by local community centres and groups and highlight the added value of the pilot as a gateway to a wider pool of community level provision. This is highlighted by figure 3.1 (overleaf) which provides an overview of referrals out to the VCS by service type. It shows that the most frequently accessed services are:

- community based activity (268 referrals, 22 per cent), including;
 - social and leisure activity (175, 14 per cent)
 - exercise (93, eight per cent).
- information and advice (187, 15 per cent), including;
 - benefits (100, eight per cent)
 - other areas (87, seven per cent)
- befriending (133, 11 per cent)
- community transport (106, nine per cent)
- enabling (92, eight per cent)
- complimentary therapy (72, six per cent).

However, what is perhaps most striking about this pattern of referrals is the broad range of services accessed through social prescribing. In addition, the high demand for services such as befriending and community transport highlights the importance of services that aim to reduce dependence and social isolation. These types of intervention might be seen as a 'first step' for patients aiming to access a wider range of community provision more independently in future.

A further, unintended effect of the pilot has been to make referrals to statutory sector services. So far, 243 patients have been referred to additional statutory provision, with the highest proportion being to falls prevention, the 'Active Always' health and fitness programme, and rehab services in intermediate care. Although it cannot be said for certain that these referrals would not have occurred eventually through other means, in many cases it has ensured that the referral happened sooner rather than later.

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



3.4. Impact

Reducing hospital episodes

One of the main NHS Rotherham CCG motivations for funding the pilot was to understand the impact of the social prescribing model on costly hospital-based interventions for people with LTCs. It is known that people with LTCs are proportionately higher users of health services and account for more than half of GP appointments, outpatient and Accident and Emergency attendances, and in-patient bed days. The ability of the Social Prescribing Pilot to demonstrate positive impact on its beneficiaries' need for health services will therefore be a key measure of its success. In particular NHS Rotherham CCG are interested in understanding whether or not the resources invested in the pilot can be justified over the longer term based on the resource savings that are created.

In order to understand the impact of the Social Prescribing Pilot on hospital episodes the Evaluation Team has been granted access to pseudonymised NHS hospital episode data for all patients that are referred to the pilot. The data covers a period prior to and following their referral so that changes over time can be tracked. Data on Accident and Emergency presentations (including whether ambulance transfer was required), hospital admissions, and outpatient appointments has been provided.

To date, analysis of hospital episodes has focussed on a cohort of 161 SPS clients for whom data was available for the six months prior to and preceding their SPS referral. The cohort includes clients referred to SPS between August and December 2012. The findings of this analysis are summarised in table 3.2 and discussed below. However, it is important to note a number caveats at this stage:

- the time lag in the data provided means it is not yet possible to analyse episodes data for patients who have been referred from January 2013 onwards
- the number of cases in the cohort is relatively small and therefore can be potentially skewed by large variations in individual cases
- this data represents the very early stages of the pilot, when not all of the services had been established, and the service was still 'finding its feet'
- the six month time window does not allow for variations due to weather or seasonal norms to be accounted for.

Table 3.2: Overview of change in hospital episodes (Social Prescribing referrals Aug-Dec 2012)

		A&E	Admissions	Outpatients
Number of episodes before		173	126	148
Number of episodes after		136	115	105
Change in episodes	<i>n</i>	-37	-11	-43
	%	-21%	-9%	-29%
% of patients with fewer episodes		50%	43%	51%

This demonstrates that reductions in all three types of hospital episode were identified compared to the six months prior to referral:

- Accident and Emergency attendances reduced by 21 per cent
- hospital admissions reduced by nine per cent
- outpatients appointments reduced by 29 per cent.

It also shows that around half of all Social Prescribing patients experienced reductions:

- 50 per cent had fewer Accident and Emergency attendances
- 43 per cent had fewer hospital admissions
- 51 per cent had fewer outpatient appointments.

It is worth noting that of the Accident and Emergency attendances covered by this data 44 per cent of those in the six months prior to referral resulted in admission to hospital compared to 51 per cent of those in the six months following referral. This might be evidence of fewer 'unnecessary' Accident and Emergency presentations in the post-referral period amongst this cohort.

Although it is not possible to attribute these changes to Social Prescribing at this stage, the findings should be interpreted as positive sign of the potential of the service to have an impact on reducing resources in the longer term. When the final evaluation report is published in 2014 the analysis will cover a 24 month window: 12 months prior to and following referral. This will enable a robust assessment of impact.

Social outcomes

The pilot measures patients' progress towards social outcomes through an 'outcomes star' style tool developed specifically for the service. The star is completed with VCSAs when patients are first referred to the service with progress measured after approximately six months. The tool has eight measures associated with different aspects of self-management²:

- 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.

Initial analysis of data collected through this outcome tool shows patients are experiencing positive outcomes. Of the patients for whom progress has been assessed, 78 per cent experienced change in at least one area. Furthermore, of the outcome categories scoring low (two points or less) at referral, 58 per cent recorded an increase after six months. When this is broken down by category it shows that:

- Feeling Positive: 43 per cent made progress
- Lifestyle: 45 per cent made progress
- Looking After Yourself: 38 per cent made progress
- Managing Symptoms: 40 per cent made progress
- Work, Volunteering and Other Activities: 50 per cent made progress
- Money: 66 per cent made progress
- Where You Live: 62 per cent made progress
- Family and Friends: 47 per cent made progress.

² For each measure a five point scale is 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.

Learning from the pilot

This section draws on qualitative interviews with public sector stakeholders, project staff, and voluntary and community organisations (VCOs) delivering services, as well as two in-depth case studies involving service beneficiaries, to draw-out the main learning to have emerged from the pilot so far. The evidence is discussed under several themes:

- the 'action learning' approach to the pilot
- the effectiveness of the Rotherham social prescribing model
- the additionality of the services provided
- examples of added value
- the outcomes and impact of the pilot to date
- sustainability and future funding.

Six patient case studies in Appendix 1 provide more detail about the types of support provided through the pilot.

4.1. Action learning

The ability of the pilot to respond flexibly to the needs of patients, carers and provider organisations consistently emerged as one of the strengths of the service. It is likely that this 'action learning' approach to delivery was enabled by the fact that the service was established as a pilot rather than a mainstream service. Several examples of the flexibility and responsiveness exhibited by the pilot are highlighted below.

Identifying and plugging gaps in service provision

VCS service providers reflected positively on the way that VAR, as the lead organisation, has been able to listen and respond to new needs as they emerge.

"VAR has identified gaps...in service provision and attempted to fill these by asking for specific provision...in subsequent funding rounds."

(VCS Provider)

For example, the need to provide support to carers of patients with LTC was identified early in the commissioning process and a number of services were funded that specifically addressed gaps in service provision for carers. The provision for carers has been particularly popular receiving high volumes of referrals.

A further example is the development of services tailored specifically to patients from black and minority ethnic (BME) communities, and more proactive engagement with GP practices with high proportions of BME patients, in response to lower than expected referral numbers from this client group.

"...people (from BME communities) were not aware of it, to put themselves forward or ask for (support)...(the VCS organisation) actually spoke to VAR and the commissioners...about BME didn't know what services are out there..."

(VCS Provider)

Although referrals of BME patients remain proportionately low, providers acknowledged that the throughput had increased, particularly amongst women.

A final example is the pilot's work with Rotherham Community Transport to address access to transport as a barrier to accessing funded services. This has involved the development of a 'volunteer driver' scheme to help people with limited mobility access appropriate activities. So far more than 1,200 journeys have been made to support social prescribing patients to access services that they would have struggled to engage with.

"Not having accessible transport to get to activities is an issue for the majority of patients. There will always be a demand for specialist transport services but using community transport has met some of this demand."

(VCS Provider)

Developing alternative models of referral

As the pilot has developed a number of funded providers have suggested alternative approaches to referring patients and carers to the service. VAR has taken this feedback on-board and developed a number of alternative models of referral. In effect, these new models serve as a 'pilot within the pilot' and have enabled VAR to test a number of different approaches to service delivery and referral.

In the first example, a number of funded 'community hub' based providers, who act as a gateway to a wide range of community level activities, have taken over assessment and referral from the VCSAs.

"(When VCSAs) did the initial assessment of patients using Outcome Star this led to a stream of people asking similar questions, which takes it away from the person centred approach we wanted it to be, they (VAR) allowed us to take the direct referral....the first point of contact would be us and I think that's worked"

(VCS Provider)

This model has the combined effect of reducing the workload of VCSAs and forging closer ties between patients and the communities in which they live. It also makes it easier for patients to sample a wider range of activities in support of their LTC.

In a second example VAR has developed a procedure for provider led referrals. VCS providers are able to identify new or existing service users that they think might be eligible for and benefit from social prescribing. This information is provided to the relevant ICMTs who can review their eligibility and make a formal referral to the pilot if appropriate. Similarly, VCS providers are able to refer existing social prescribing patients to other appropriate VCS services (in their own organisation and other VCOs). Some of these organisations receive SPS funding but many do not. As the

pilot has developed VAR has taken a number of steps to streamline these referral processes and many providers reflected that efficiency has improved as a result.

Improving communication

Effective communication was regarded by stakeholders and providers as key to the successful delivery of the pilot. Several communication channels were seen as particularly important.

Communication between VAR (and VCSAs) and GPs/ICMTs

At the beginning of the pilot VAR had some difficulty getting some GPs and ICMTs to engage with social prescribing. A significant amount of time has been spent raising awareness of what the pilot has to offer and the potential benefits for patients. In the year since the service has been receiving referrals there has been a steady increase in the number of GP practices engaging with the pilot and the number of patients being referred. VCSA involvement in ICMTs was seen as a crucial factor in improving communication and raising awareness amongst health and social care practitioners of the pilot and about the VCS services available.

"(The pilot) has provided the practice with a resource...access to VCSAs who hold a range of information about VCS services."

(Rotherham GP)

"The VCSAs and social workers have a close working relationship so can ask for input into each other's patients and refer between their selves if a specific need is identified."

(Social Worker Assigned to the LTC Pilot)

Communication between VAR (and VCSAs) and VCS providers

VCS providers considered effective communication between themselves and the project team at VAR to be particularly important. They needed to be able to communicate with the Project Manager regarding the practicalities of delivering the service, raising issues and needs as they emerged. They also needed to have effective communication with VCSAs to ensure that they received a steady flow of referrals, and that the referrals they received were appropriate. Although communication was not always perfect, the general view was that this had improved considerably as the pilot had progressed.

"The advisors are personal, professional and get to know the client...every client I have been to has been very clearly informed about their role (advisor's) and what is going to happen. They give me a lot of clear information which is helping me to understand their role and also my role.....they have to be efficient because they are seeing a lot of patients and they have to refer within a reasonable time period to an organisation."

(VCS Provider)

Communication between VCS providers

VCS providers felt it was important that they were aware of which other VCS services were available through the pilot so that they could refer existing patients if additional support needs were identified. However, although a spreadsheet of services was provided by VAR, it was felt that this information was not sufficiently detailed during the early stages of the pilot and many providers felt they were 'in the

dark' about what else was on offer. This has improved considerably in recent months, particularly since a networking event in September 2013 when VCS providers were able to meet-up and discuss their services in detail.

"I realised how limited my awareness of other providers was when I attended the provider event recently"

(VCS Provider)

"Within half an hour I'd met three different (services) who I could refer clients to. Face-to-face meetings are better than written information although the spreadsheet is helpful to pinpoint providers in certain areas."

(VCS Provider)

A number of VCS providers also commented that VCSAs would have benefitted from attending this event given the challenges of maintaining a working knowledge of more than 30 different social prescribing activities. It was also felt that awareness raising and information sharing between providers ought to be an on-going process.

4.2. The effectiveness of the Rotherham model

Stakeholders were asked to reflect on the effectiveness of the Rotherham social prescribing model, particularly VAR's role as the lead organisation the model of using VCSAs to facilitate the referral process.

VCS providers were largely positive about the model of delivery and the role VAR plays in managing the pilot.

"(VAR) is vital on this project...because (our organisation) hasn't got a relationship with social care or health commissioners."

(VCS Provider)

"A lead organisation is needed to co-ordinate the various services and provides a key link to health."

(VCS Provider)

A number of providers felt that VAR's understanding of and reach into the VCS across Rotherham, and the fact that it does not provide frontline services itself, meant it was uniquely placed to co-ordinate the pilot and commission social prescribing services from local VCS organisations.

"(The service) should be managed by an independent organisation from health."

(VCS Provider)

"It makes sense that the body that represents the sector holds the contract."

(VCS Provider)

"They (VAR) have vast knowledge of the VCS. Their links with organisations throughout the community are invaluable."

(VCS Provider)

However, a small minority of providers questioned the need for VCSAs, and felt they could receive referrals from GPs directly.

"A link person for...the VCS is important but not VCSAs who do assessments...as this work is duplicated by the VCS when the patient is referred to them."

(VCS Provider)

"I would question the need for advisors...They were bringing in people they had to train...who would never have the understanding of what this sector (at a community level) has to offer."

(VCS Provider)

Public sector stakeholders also valued the role VAR plays in co-ordinating the pilot, highlighting its knowledge of the sector in Rotherham, and the efficiencies associated with a single service delivery contract as particular benefits. Importantly, they were very positive about the VCSA role.

"The difficulty for GPs is because they do everything...that an individual GP might have potentially hundreds of services to which they might refer and...trying to keep 150 GPs across Rotherham completely up-to-date on every single service that exists is never going to happen. The VCSAs play a crucial role, it wouldn't work without them."

(Rotherham GP)

"From a commissioner perspective you have a single contract, it makes life much simpler than dealing with a multitude of providers. VCS organisations require a conduit, which VAR is."

(GP Commissioner)

"VCSAs bring a breadth of knowledge about existing and new VCS services that are being introduced, how funding is being used ...they are letting the health professionals know what's available so when they see their patients, they can refer out...people still like to see someone, to talk to someone, rather than try to find that information themselves...if you take them the first couple of times, they then go...and the advisors do that, they take people places to get them settled, comfortable and then they can pull out. I think it needs the advisors".

(Social Worker Assigned to the LTC Pilot)

However, a number of concerns were raised regarding the cost-effectiveness of the model, particularly if it were to be integrated into mainstream provision in the longer term.

"For it to be plausible and cost effective, it does require a large number of people to be seen for the amount of money invested...the amount of funding would have to be proportionate to the number of people who are likely to be referred and then the number of those who have the capacity to benefit".

(CCG Officer)

"(The pilot) could be seen as an add-on or a luxury in terms of funding, it would be quite difficult to prove that the absence of this would lead to that if it's measured against a reduction of nurses or a reduction of doctors and it's very

difficult to say we've seen this number of people and if this social prescribing scheme wasn't there then this would've happened, where as you can very clearly with health and LA services say if the funding for this is removed, then that's the consequence'

(NHS Officer)

A number of VCS providers and public sector stakeholders commented that the effectiveness of the pilot was limited by the risk stratification criteria used to determine eligibility for support. It was felt that by focussing on the five per cent most intensive users of health services an opportunity to achieve a broader range of preventative impacts was being missed.

"I wish they could continue (the pilot) for patients who are also on level 1 & 2 (risk assessment) to try and prevent them from reaching level 3. If we can get those people earlier, we may reduce admissions to hospital in the longer-term."

(Social Worker Assigned to the LTC Pilot)

"The SPP would have more impact if cohorts of people from the top 20 per cent were identified instead of from the top 5 per cent. It would be more preventative rather than reactive."

(CCG Officer)

4.3. Additionality and new providers

The vast majority of VCS activities funded through the pilot are additional. Funding has been used to set-up completely new services that were not available before and to create additional capacity in existing services. In addition, a number of VCS providers have been commissioned to deliver publicly funded health and social care services for the first time. This has had the cumulative effect of increasing the overall range, scope and volume of services available to patients with LTCs.

"Previously, advocacy work (in our organisation) was unpaid...the social prescribing advocacy project came about as a direct response to low numbers of BME people referred to VCS services"

(VCS Provider)

"(The service) is different, because various groups and organisations hire space at the centre and recruit their own service users, but the social prescribing service delivered through the centre links referred patients with these groups and organisations, if they have the capacity"

(VCS Provider)

4.4. Added value

Public sector stakeholders highlighted the added value provided by the various VCS activities funded through the pilot. In particular, they emphasised the benefits for public bodies beyond the CCG as commissioners of the pilot. The local authority, through benefits in the areas of social care and public health, were identified as direct beneficiaries even though they have not funded the pilot.

"Quite a few patients wouldn't meet Health and Social care 'Fair Access to Care Services' (FACS) criteria...whereas they would through (the pilot), because we can access their services within this scheme things seem to be done a bit more quicker for the patient."

(Social Worker Assigned to the LTC Pilot)

"(Public Health benefits through) the preventative type work... providing services upstream so people don't subsequently deteriorate."

(NHS Officer)

This is a view that was echoed by VCS providers.

"Social care are benefiting on the back of this because a lot of what we do is at the interface between health and social care. A lot of people who are turning up at their GP are not an immediate primary health issue, it's a longer term lack of care issue and that puts a strain on the carers, so the carers are turning up at the GPs depressed, down, overstressed, and actually because the support isn't in the health and social care."

(VCS Provider)

A further example of the added value provided through the pilot is its ability to act as a pathway for patients to access a wider pool of VCS services that are not directly funded through social prescribing. This includes services available through the same provider and other local VCS providers.

"We use funds from other projects to support social prescribing, if necessary....it's about using all our resources. It's a holistic approach about how we use our resources as well"

(VCS Provider)

"We have referred people on to Rotherham Citizens Advice Bureau if they've needed further support. It's like giving a very personalised individual service, very person centred."

(VCS Provider)

This is particularly important for patients who are socially isolated or lonely as it provides an opportunity to access and initiate activities that can support them to become more independent.

"(Patients) have developed (social) groups outside of the (core social prescribing) service, going on walks out, meals etc"

(VCS Provider)

"(The organisation) also provides other services (that can be accessed)...a welfare advisor, who can provide benefit checks and other information for patients. We also have relationships with other organisations...so can take shortcuts in finding help for patients."

(VCS Provider)

A final example of the added value of services provided through the pilot is the volunteer resources utilised. Although the majority VCS providers employed paid staff to co-ordinate and deliver services, they also relied on trained and committed volunteers to supplement these activities. Although there are some costs associated with these volunteers (expenses, training, management etc), they represent a considerable cost-efficiency to the pilot as a whole.

"(We have) two volunteers who do 20-30 hours per week, including evenings and weekend work."

(VCS Provider)

"Volunteers in sessions support the musicians to help stimulate responses from people with dementia."

(VCS Provider)

"An older volunteer offers befriending support...and accompanies the counsellor during home visits. He is trained in first aid and has knowledge about accessing medical services, if needed."

(VCS Provider)

4.5. Outcomes and impact

Although the evidence for this report was collected relatively early in the pilot and the evidence suggests outcomes and impact can take several years to materialise, a number of examples of impact have emerged. At this stage these provide an illustration of the types of outcomes and impact that might occur more widely as a result of the pilot in the longer term.

1) Patients moving from dependence to independence

"One patient's Support Worker initially made the transport booking for her, but now the patient has grown in confidence and has started to make bookings herself, making decisions about places she'd like to go, activities she'd like to get involved in. Introducing this individual to dial-a-ride, accompanying her on initial journeys, has prevented this individual from being isolated at home."

(VCS Provider)

2) Patients moving towards self-efficacy in the management of their condition

"People feel that they have more control over their health and they learn different techniques as ways of helping to develop the things that are important to them...proper breathing, learning how to deal with stress, learning how to relax, how to balance, how to move...."

(VCS Provider)

3) Reduced social isolation for patients and carers

"Reduction in social isolation...increased social interaction, which has an effect on quality of health...more likely to take care of oneself, and be alert...People have made friendships within the group and do telephone each other."

(VCS Provider)

"Isolation is being addressed...we have been able to meet specific needs, like with the gym...it brings people into the community...they suddenly become part of something. A lot of people are giving back by supporting each other."

(VCS Provider)

4) Improvements in the quality of care provided

"The quality of contact with the patient has improved... because we have more options to discuss with the patient in terms of the services available and the VCSA plays a crucial role in engaging with them."

(Social Worker Assigned to the LTC Pilot)

"It's made a difference to the quality. When we do a joint visit together I think that person gets a better quality in the sense, I can look at the adult services side of things and the voluntary sector can look at things that wouldn't have met our criteria...the voluntary worker can do more than signpost, they can physically take the person, stay with the person at the activity to get them settled."

(Social Worker Assigned to the LTC Pilot)

In addition to these examples, public sector stakeholders talked in general terms about the types of outcomes and impact they hoped would emerge from the pilot.

"(Primary Care benefits because the pilot is) supporting people along a pathway of care...GPs, Community Nursing & other Primary Care teams can only provide an element of care...it's the missing part of the jigsaw in terms of maintaining people at home".

(NHS Officer)

However, for many public sector stakeholders, particularly commissioners, an important test of impact was whether or not public sector resources were saved as a result of interventions funded through the pilot, as well as the obvious social benefits.

4.6. Sustainability and future funding

Interview participants from the VCS and public sectors were asked to consider if, and how, the pilot and the activities it has supported could be sustained if CCG funding for the pilot was not continued beyond March 2013. Respondents were clear that it would be very difficult to sustain the current model without core funding of some sort, and that withdrawing the services would have considerable negative effects for patients.

"It's taken me months to get them (patients) to trust me.....for that to then stop, it's like ripping the rug from under their feet and the concern is that we're just going to take a massive step back and the patients are going to end up if not at square one, even further back".

(VCS Provider)

"My concern is that I'm working with people who perhaps haven't accessed groups for a long time...I don't want to set them up with all these social prescribing projects and then find out it all stops at the end of March. I've also

had to find them other activities that are 'mainstream' so that if the worst comes to the worst they still have somewhere to go".

(VCS Provider)

"No (the service is not sustainable). The funding is needed to establish the new (services), deal with referrals and set up new activities. In the long-term, if services are running at capacity there might be a possibility of covering costs."

(VCS Provider)

However, a number of options for future funding, particularly of specific services and activities, were identified. This included enabling patients to use their direct payments and individual budgets to access services, and encouraging self-funding of some activities.

"One patient has started to use her direct payments for support...(the organisation) might be able to benefit from Direct Payments more."

(VCS Provider)

Weekly activity sessions take place, including Community Transport with a patient contribution of £2.50. Sessions... include, tea, coffee and catch-up, gentle exercise, healthy eating, nutrition advice, reminiscence, life stories, games, creative writing, lunch. Patients pay a £3 charge for session. We didn't anticipate that most people would need transport. These costs were underestimated."

(VCS Provider)

Conclusions and recommendations

This report has provided interim findings from the independent evaluation of the Rotherham Social Prescribing Pilot. Although the pilot has not concluded and the evaluation is still in its early stages some important learning has emerged. This final chapter summarises this learning through a series of conclusions and recommendations for all stakeholders in the pilot. It also outlines a series of next steps for the evaluation, particularly as it moves towards providing a fuller assessment of outcomes and impact.

The pilot is one of the most extensive social prescribing initiatives currently being undertaken. It has a number of unique and innovative features, including a comprehensive model for identifying patients with LTCs eligible for support, assessing their needs and the needs of their carers, and making onward referrals to appropriate VCS services. As a result the pilot has attracted considerable interest from policymakers, practitioners and academics alike. As such the learning identified through the pilot and the conclusions and recommendations outlined in this report will not just be applicable locally but also nationally, as social prescribing interventions are developed in different places and different contexts.

5.1. Conclusions

Through the evaluation a range of benefits have been identified for different stakeholder groups:

1. **The CCG, GP practices and the wider NHS** benefit from the opportunity to refer patients with LTCs to a menu of new and innovative community based services that complement traditional medical interventions. VAR and the VCSAs provide GPs with a vital gateway to these services and act to identify and plug gaps in provision. There are a number of signs that these interventions could help reduce demand on costly hospital episodes in the longer term.
2. **Other public sector bodies, particularly local authority public health and social care**, benefit from a broader range of services that can be accessed by local people with complex needs. It is possible that a wider series of preventative benefits will emerge over a longer period. There are strong links between the pilot's achievements and the borough's Health and Well-being Strategy and Commissioning Plan.
3. **People with LTCs and their carers** benefit from an alternative approach to support. There is evidence that patients and carers have

experienced positive outcomes associated with their health and well-being, and are becoming less socially isolated and more independent.

4. **Funded VCS providers** have benefited from the opportunity to broaden and diversify their provision for people with complex needs. In particular, it has enabled a number of smaller community level providers to engage with health commissioning for first time, whilst enabling more established providers to test the effectiveness of new and innovative types of provision. More broadly, the pilot has helped to raise awareness and demonstrate to commissioners the potential of VCS providers to contribute to local strategic health priorities. Ultimately this development could lead to a more sustainable VCS in Rotherham at a time when resources for its activity are increasingly scarce.

5.2. Recommendations

Having considered the evaluation evidence collected to date we make a number of immediate and longer term recommendations: for VAR, for VCS providers, and for the CCG and wider public sector.

Immediate recommendations

1. Effective communication between VAR and VCS providers, and between different VCS providers, is crucial to the ability of the pilot to function effectively. It is important that the progress of the past few months is sustained and consideration given to how **more frequent face-to-face contact between providers** can be facilitated.
2. The NHS and public sector partners **need to quickly provide a clear message about the future of the service**. The pilot has built up a considerable head of steam over the past 18 months but there is a danger that this could be lost if a decision about re-commissioning is not made soon. VAR and many of the providers have employed staff on fixed term contracts that expire at the end of March 2014: this means issuing redundancy notices in the New Year and the possibility of skilled and knowledgeable staff moving on if the future of their employment cannot be guaranteed.

Longer term recommendations

3. There is strong evidence to suggest that **the Pilot should be continued for at least another year** (i.e. to March 2015). This will provide sufficient time to identify the longer term outcomes and impacts of the service. Also, without the funding provided through the pilot the majority of services would not be sustainable, and the withdrawal of these services before their full effects have been realised could result in a variety of disbenefits or negative outcomes for patients.
4. An extension to the pilot would benefit from **funding from the local authority (public health and/or social care) as well as the CCG**. Given the possibility for preventative benefits and the links to the Health and Well-being Strategy, there is a strong case for funding an extension to the pilot through the Integration Transformation Fund (ITF).
5. The pilot has provided important funding to co-ordinate and enhance VCS service provision but there is evidence to suggest **the funding base could be diversified**. Options include widening opportunities for direct payment and individual budget holders to purchase services, and encouraging more frequent self-funding of certain activities. If, in the longer term, there is sufficient evidence

of public sector resource savings, it would be worth exploring the feasibility of commissioning social prescribing services through a social impact bond (SIB).

6. In some ways the scope of the pilot has been limited by its connection to the Case Management Pilot and the requirement to target the five per cent most intensive users of health services. In the future, the option for the pilot to also **target patients who are currently less intensive users of health services** should be considered. This would enable a wider range of preventative benefits to be realised, particularly in areas such as mental health and well-being.
7. Future configurations of the Social Prescribing Service should consider the possibilities of a **more flexible referral and assessment model** with a view to improving cost efficiency and cost effectiveness. The community based model that has been tested through the pilot could be rolled-out to other neighbourhoods. In some neighbourhoods this would mean building on existing capacity and resources (volunteers, community groups, etc.) but in others additional capacity would need to be created. The effectiveness of provider-led assessment and referral could also be explored, particularly for groups of patients from specific groups (such as BME communities) or with particular needs (such as acute mental health problems).

5.3. Next steps

The evaluation will run alongside the pilot until it concludes in March 2014. At that point it will be in a position to provide a fuller assessment of impact. This will involve a number of tasks:

- analysis of hospital episode data for patients engaging with the pilot between September 2012 and February 2013: this analysis will cover a 24 month period (12 months prior to referral and 12 months following referral)
- analysis of outcome data for all patients engaging with the pilot
- analysis of referral data for all patients engaging with the pilot
- analysis linking data on hospital episodes, outcomes and referrals or patients engaging with the pilot between September 2012 and February 2013: this analysis will enable a comprehensive understanding of the relationship between different types of social prescribing activity and the outcomes achieved for patients
- case study work, including patient interviews, with three further VCS providers
- follow-up interviews with a number of public sector stakeholders.

Following these tasks a final evaluation report will be published in early summer 2014.

Appendix 1: Case studies

Case Study 1: Crossroads Care

Organisation

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

Services provided through Social Prescribing

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

- **flexible respite** (30 hours over an 8 week period)
- four **complementary therapy** sessions
- various **training options** such as 'Moving & Handling', 'Health & Safety' and 'Caring with Confidence' training
- **information and signposting**
- a **coffee morning** to bring carers together is also being set up.

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

Sustainability

Crossroads is a large organisation and receives funding from various sources; if the social prescribing service was lost through no further funding, the organisation could continue to operate, although the Social Prescribing Project Coordinator post would be lost. A few carers have expressed an interest in purchasing additional services such as respite care, and this is already happening through, for example, Direct Payments. The new model developed for social prescribing may open up other opportunities for securing funding from the NHS.

Patient case studies

Mrs A

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

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

Mrs B

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

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

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

Mrs C

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

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

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

Case Study 2: Age UK Rotherham

The organisation

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

Services provided through Social Prescribing

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

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

Added value

Each patient referred to Age UK Rotherham through the Social Prescribing Service has access to the full package of support available from the organisation even though they may have only been referred to a particular service, for example, the Befriending service. The individual is asked about benefits, smoke alarms etc. Once a referral is received, Age UK do an holistic assessment *'which touches on all aspects of that older person's life'*, so a Befriender can also pick up on the older person's needs and report back, *'bringing other services to them'*. *'That external package is always there'*.

A range of core and flexible services are available: advice and information; paid for services such as domestic cleaning, handypersons, gardening, low-level care, independent living support, and the Social Centre; are provided between 9am and 4pm, but the organisation continues to deliver outside of these hours at weekends and bank holidays, *'it's very much about personalisation and if it's not written down, it doesn't mean to say we don't do it....we can build packages for them.....It's all built around what that person wants'*.

Sustainability

The Social Prescribing Service funding has *'given us a wider base to build our finances on....it's spread the overheads a little bit further.....it supports the befriending aspect which is something that we want to do as an organisation anyway and so the funding is helping to support that'*. The social prescribing activity would not be sustainable without funding and jobs would be lost.

Patient Case Studies

Mrs A

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

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

Mrs B

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

Mrs C

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

Appendix 2: Overview of funded social prescribing services in Rotherham

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

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

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

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