



Evaluating Social Prescribing 'Plus' in Rotherham: key findings and lessons for policy and practice

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Introduction

- What is social prescribing and why are we talking about it now?
- Different models of social prescribing: introducing social prescribing 'plus'
- Social prescribing 'plus' in practice: the Rotherham model
 - Key features of the model
 - (Micro-)commissioning and referral pathways
- Evaluation findings
 - Mental health pilot
 - Long term conditions update
- Concluding thoughts:
 - Social prescribing 'plus' as best practice in taking an asset-based approach to health
 - Getting started with social prescribing 'plus' in your area

Some background information

- CRESR at Sheffield Hallam University is a leading national policy research centre
- Voluntary and community sector involvement in public sector service delivery is a key area of our work
- We are currently involved in a number of local level social prescribing evaluations:
 - Rotherham, since 2013; covering LTCs, mental health. Also evaluating 'Carer's Resilience Service' for Dementia Carers
 - Doncaster, since 2015
 - Essex, since 2016; as an advisor to PACEC
- Informal advice and guidance provided to a wider range of social prescribing projects being developed across the country
- Interested in understanding social prescribing from different perspectives: patient, commissioner and VCS organisations

Social prescribing outputs to date

Dayson, C., and Bennett, E. (2016) [*Evaluation of Rotherham Mental Health Social Prescribing Pilot*](#). Sheffield: CRESR, Sheffield Hallam University

Dayson, C., Bashir, N., Bennett, E. and Sanderson, E. (2016) [*The Rotherham Social Prescribing Service for People with Long-Term Health Conditions: Annual Report*](#). Sheffield: CRESR, Sheffield Hallam University

Dayson, C. (2016). [*Evaluating social innovations and their contribution to social value: the benefits of a 'blended value' approach*](#). *Policy and Politics*. (In Press)

Bashir, N. and Dayson, C. (2014) [*The social and economic impact of the Rotherham Social Prescribing Pilot: Main Evaluation Report*](#). Sheffield: CRESR, Sheffield Hallam University

Dayson, C., Bashir, N. and Pearson, S. (2013) [*From dependence to independence: emerging lessons from the Rotherham Social Prescribing Pilot*](#). Sheffield: CRESR, Sheffield Hallam University

What is social prescribing?

- A very broad, overarching, catch-all term:
 - A **noun**: non-medical service(s) in the voluntary and community sector for people with limiting and/or long-term health conditions
 - A **verb**: referral process and pathways into the voluntary and community sector available to GPs and other health practitioners
 - Both meanings often used in combination and/or interchangeably
- Its been around for more than 15 years, mainly as a 'bottom-up' idea, but rapid 'top-down' growth since 2012
- But...Social Prescribing is not one 'thing', and there are risks associated with assuming it is
 - No universal coverage across the UK - geographically uneven
 - Different models and funding levels in different places
 - Requires well developed and well resourced local 'assets'

Why are we talking about SP now?

- Social prescribing is a feature of current policy debates: interest in its implementation nationally and locally
 - NHS/DH recognition that non-clinical interventions can benefit General Practice (DH, 2006; NHS England, 2014).
 - Included in local Sustainability and Transformation Plans (STPs)
- Why now?
 - **Austerity, and a 'crisis' in the NHS:** need to find new ways reduce demand on primary, secondary and social care
 - **Integration and transformation:** focus on multi-disciplinary working at a community level
 - **Growing clinical understanding of 'asset-based' approaches:** well-being and connectedness of patients becoming a priority
 - **Reaping the benefits of partnership working:** key people in the voluntary and public sectors winning the case for SP locally

Models of social prescribing

- Social prescribing exists on a continuum of varying scale, scope and intensity.
- Kimberlee (2015) says there are four broad types:
 - SP as **signposting**: patients are informed about local SP options but not supported to access them
 - SP **light** and SP **medium**: patients referred to specific programmes for specific reasons e.g. arts, exercise or well-being on prescription; some additional signposting to wider SP options
 - SP **holistic**: formal referral mechanism or pathway exists for referrals; directly commissioned through primary or social care; person-centred approach to identifying needs; support to access services and activities
- Current trend/ambition is towards **SP holistic** - often through Better Care Fund - but this masks some major challenges that commissioners are not always aware of

Models of social prescribing

- There are a number of challenges associated with many supposedly holistic approaches to social prescribing:
 - **Existing voluntary and community services not set-up to meet specific needs:** many SP clients need bespoke 'first-step' or 'gateway' services to enable engagement
 - **Supply can't meet the additional demand:** voluntary and community services under/un-funded and/or already at capacity - leads to backlogs and negative consequences for patients
 - **Accessibility of services:** transport a barrier for many, not all services available at a community/neighbourhood level
 - **Sustainability of voluntary and community organisations:** lack of funds/volunteers restrict ability to meet the needs of SP patients
 - **Lack of co-ordination and awareness of SP options:** involvement of local VCS infrastructure (CVS or VA) can be key
- **Social prescribing 'plus'** can help address these challenges

Key features of social prescribing 'plus'

- **SP 'plus'** is far broader than most *SP holistic* models
- Broad geographic coverage: city, borough or CCG wide
- Multiple clearly defined referral pathways from a variety of health settings:
 - GPs/other practitioners at a practice level
 - Statutory mental health services
 - Secondary care
- A 'menu' of SP specific services and activities is developed
- Necessitates a step-change to a **new model of commissioning** with the voluntary and community sector:
 - Significant long term investment of strategic funds across multiple service areas
 - Funding for referral pathway and SP specific services

SP plus in practice: the Rotherham model

- Rotherham is one of the few examples of SP plus
- SP is a **commissioning strategy** to enable VCS to engage in health and social care delivery, integration and transformation
- Long-term **strategic investment in VCS** from local statutory organisations, linked to key policies and strategies:
 - Long term funding commitment: since 2012, until at least 2018
 - Embedded in NHS Sustainability and Transformation Programme, health and well-being strategy and mental health transformation plan
- Broad but targeted coverage:
 - Borough wide service: available to patients across Rotherham
 - LTC service: for those most at risk of emergency admission - part of integrated case management
 - MH service: patients facing barriers to discharge and independence

SP plus in practice: the Rotherham model

- Single contract(s) to deliver LTC and MH SP referral pathways held by local VCS infrastructure (Voluntary Action Rotherham)
 - Additional services are 'micro-commissioned' by VAR based on identified gaps and needs
 - Reduces transaction costs for CCG and ensures contract management independent from front line delivery
- Several advantages of giving VAR a central role:
 - Utilises VAR's reach into and understanding of the VCS
 - Micro-commissioned services have access to additional capacity building support and partnership activities available through VAR
 - VAR has long track record of facilitating partnership working between VCS and local statutory bodies

The SP plus 'micro-commissioning' model

- 50 per cent of the Rotherham SP budget goes to 'micro-commissioned' services in the VCS
- 30+ small grants plus spot purchasing for additional service provision:
 - To provide a first-step for service users to access the VCS
 - Develop VCS capacity to meet demand for support from SPS service users
 - Enable gaps in provision to be identified and filled
 - Fosters innovative approaches
 - Enables small and community level VCS providers to engage in service provision
- Services prepare patients for onward referral to wider VCS
- Many patients become self-funders, volunteers and start-up their own peer-led groups

SP plus referral pathways

- Well established long term conditions service (since 2012):
 - 1,000+ patients engaged per year
 - Embedded in case management: eligible patients identified through risk stratification; GP refers to SP advisors (VAR), who are part of case management teams
 - SP advisor assesses needs and discusses SP options: refers on to funded services, drawing on a 'menu' of options
 - Patient attends funded service for time limited period: onward referral to wider VCS, self-funding, and/or peer-led groups
- Mental health service building on LTC approach (since 2015):
 - Step-down provision engaging 150-200 patients per year
 - Focus on clusters 4, 7, 11: patients who could be discharged if appropriate support is in place
 - 26 week pathway to enable smooth transition from MH health services: parallel support in place until week 18

Evaluation methodology

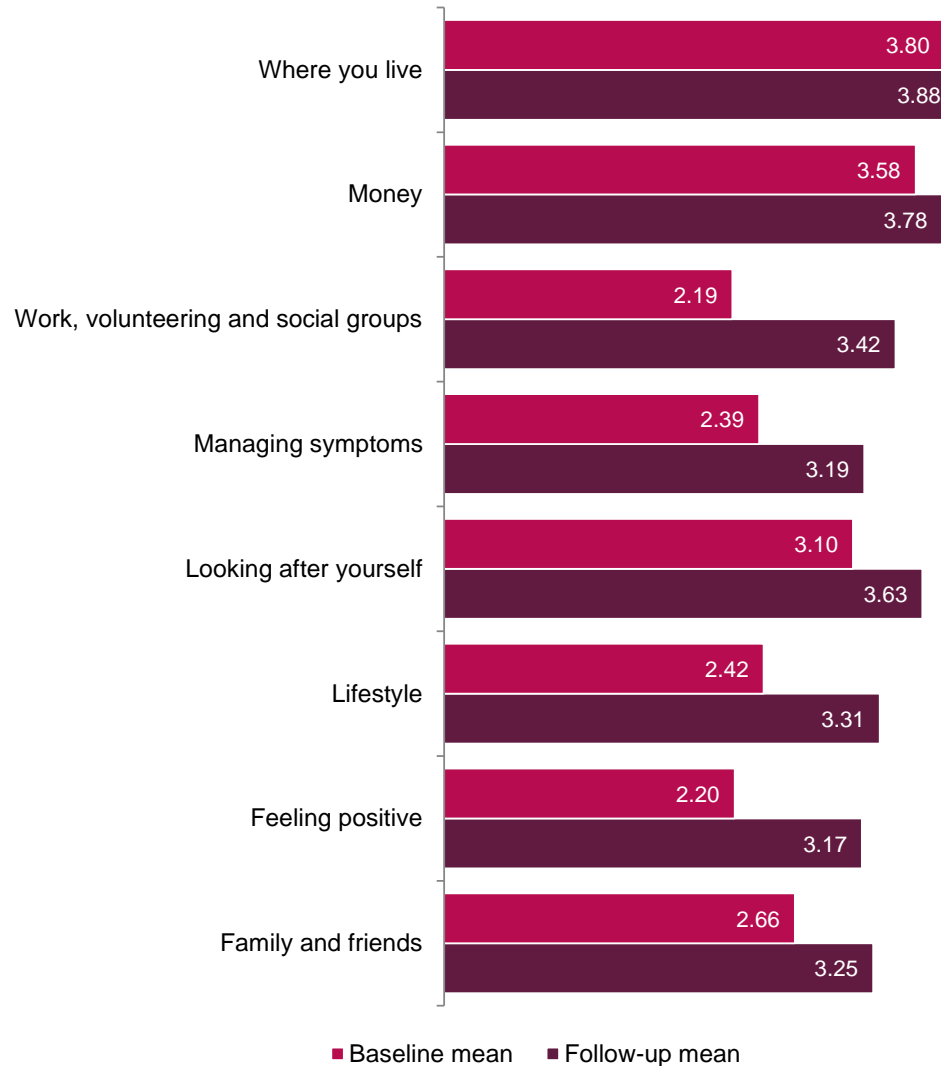
- Social prescribing in Rotherham evaluated through **mixed methods** since 2013
- Analysis of NHS primary and secondary care data:
 - Mental health: tracking patients through the referral and discharge process
 - LTCs: secondary care used 12 months before/after engagement
- Well-being surveys
 - Advisor led: data collected at first engagement and after three months
- Qualitative interviews and case studies with SP patients and services
- Qualitative interviews to capture health professional's perspectives: GPs, practice staff, MH workers,

Evaluation findings: Mental Health Pilot

1. Well-being

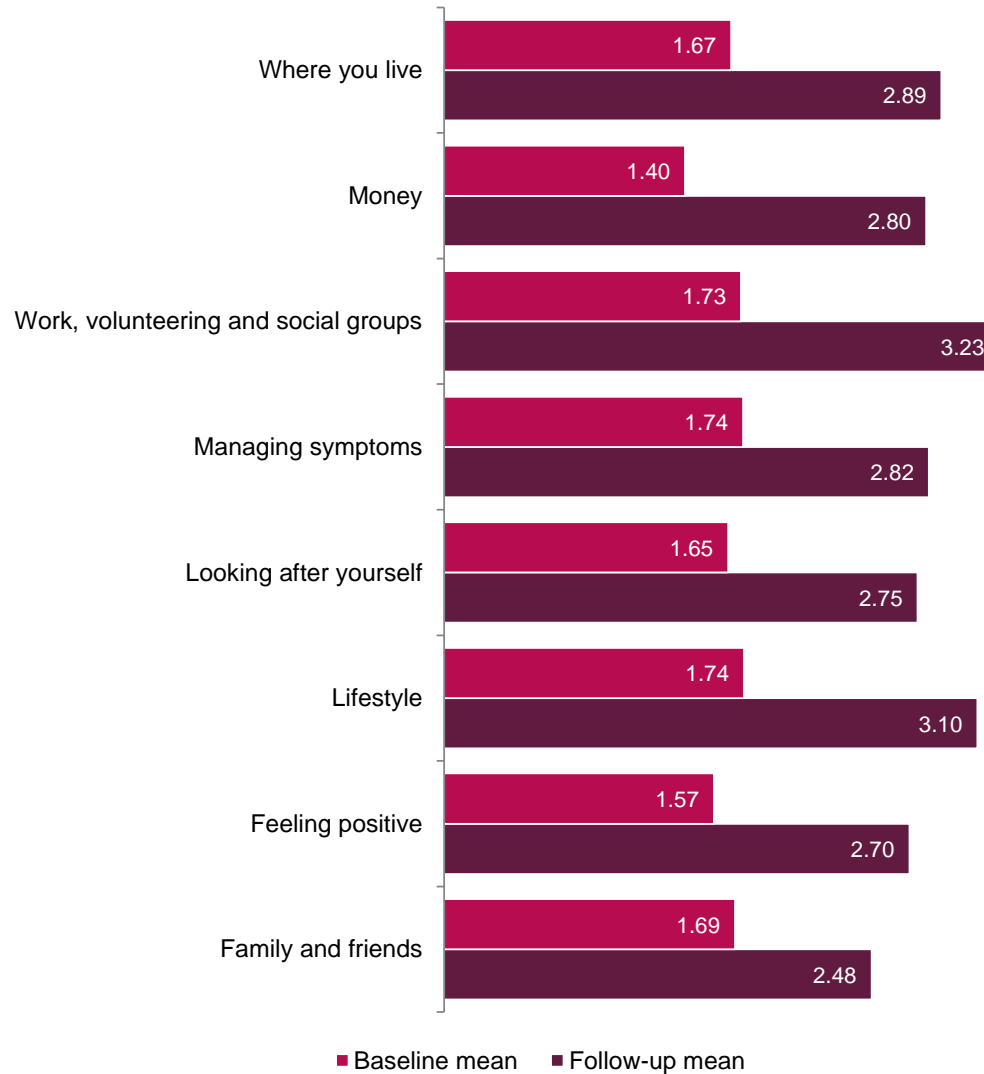
- More than 90 per cent of service users made progress against at least one (of eight) well-being outcome measure (scale: 1-5)
- More than 60 per cent made progress against four or more measures
- Those with 'low' baseline scores (2 or less) made the greatest amount of progress
- Areas where progress was most marked:
 - Work, volunteering and social groups
 - Feeling positive
 - Lifestyle
 - Managing symptoms
- Findings reinforced by qualitative case studies

Evaluation findings: Mental Health Pilot



Baseline and follow-up scores for all service users

Evaluation findings: Mental Health Pilot



Baseline and follow-up scores for low scoring service users

Evaluation findings: Mental Health Pilot

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

(Service User)

Evaluation findings: Mental Health Pilot

2. Wider benefits for service users

- Of the 94 service users who had completed the social prescribing pathway by March 2016:
 - 3 had found employment
 - 24 had engaged in training or education
 - 14 had volunteered
 - 25 had taken-up activity to improve their physical health
 - 40 had continued to engage in voluntary sector activity once their social prescription had ended.

Evaluation findings: Mental Health Pilot

3. Removing the barriers to discharge from mental health services

- By the end of March 2016 72 service users were eligible for a discharge review meeting
- Of these 54 per cent (39 service users) had been discharged from mental health services
- Only two discharged service users had been re-referred
- Qualitative research highlights importance of peer-support, volunteering and social activities for sustaining discharge
- Note of caution: too much focus on discharge, too soon, can be unsettling

Evaluation findings: Mental Health Pilot

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

(Volunteer and service user)

Evaluation findings: Mental Health Pilot

4. Economic and social value

- Fiscal and economic benefit of £4,281 per year for each additional sustainable discharge: reductions in the cost of service provision and increased earnings
- If 47 service users are discharged sustainably each year the Pilot will create fiscal and economic benefits greater than the costs of delivering the service (i.e. a positive return on investment)
- A range of benefits are possible without full discharge: fewer contacts with clinical staff, reduced prescription costs, less time spent in traditional therapies
- Wider social value estimated by monetising well-being improvements equates to up to £432,000: a social return on investment of £2.19 for every £1 invested in the pilot.

Evaluation findings: Mental Health Pilot

5. Aligned with the aim and vision of mental health policy

- Nationally:
 - Five Year Forward View for Mental Health
 - Places more value of the type of community based integrated and preventative services that the Social Prescribing Pilot provides
- Locally:
 - RDASH transformation plan
 - Need for alternatives to secondary mental health services that facilitate discharge to more appropriate and sustainable forms of support
 - Wider health and employment strategies
- Highlights the potential for wider roll out of social prescribing within secondary and primary mental health
 - Would enable the benefits identified to be realised more broadly than the current model

Evaluation findings: LTC update

- 2016 evaluation ongoing: focus on secondary care use and capturing an in-depth GP perspective
- Emerging findings reinforce conclusions of earlier evaluation reports - detailed analysis ongoing:
 - Small reduction (5 per cent) in emergency in-patient episodes
 - Larger reduction (13 per cent) in Accident and Emergency attendances
 - Greater reductions amongst younger age cohorts
 - GPs overwhelmingly positive about the impact of SP on their work:
 - Less demand on their time in surgeries
 - Able to focus on medical rather than social problems
 - Get to see patients social prescribing 'stories' first hand

Cross-cutting evaluation findings

- Broader overarching benefits:
 - SP has enabled VCS organisations to 'lever in' additional funding worth millions of pounds: sector more sustainable as a result
 - Volunteers also provide an additional 'resource' in the delivery of services
 - SP has also enabled small local level organisations to access local statutory funding and contribute to local statutory priorities for the first time.
 - Strong and constructive partnerships between local statutory bodies and local voluntary and community sector: trust and understanding
- Extending the reach of the local voluntary and community sector:
 - More than 3,000 people have been substantively engaged across the two services since 2012
 - Most had not accessed VCS in the recent past and statutory services were not addressing all of their needs.

Cross-cutting evaluation findings

- Making services more 'relational'
 - In the current climate public services cannot afford to spend sufficient time with people to understand their needs
 - Social prescribing gives people time to build important relationships that will support their recovery/management of their condition
 - This is a key benefit of most VCS services and part of what makes the SP plus offer distinct
- The importance of local infrastructure (VAR)
 - Independent: from frontline delivery; from the statutory sector
 - *Reach into and understanding of the sector*
 - Capacity building and partnership support
 - A future model of commissioning for other types of services?

Some concluding thoughts

- Social prescribing plus is an example of best practice in developing an 'asset-based' approach to health

*"Asset approaches make visible, value and utilise the **skills, knowledge, connections and potential in a community**. They promote capacity, connectedness, reciprocity and social capital.*

*The aim is to **redress the balance between meeting needs and nurturing the strengths and resources of people and communities**. Asset-based working seeks ways to **value the assets, nurture and connect them** for the benefit of individuals, families and neighbourhoods.*

The professional's role is to support people to recognise and mobilise the assets and resources they have."

Foot and Hopkins (for the IDA, 2010)

Some concluding thoughts

- How might you started get with developing social prescribing 'plus' in your area?
- Morgan (2014) identifies set of principles to support the practical implementation of asset-based approaches mirrored by SP 'plus':
 - Prioritising person-centred approaches that emphasise building positive well-being and associated psychosocial resources.
 - Involving individuals and local communities effectively and appropriately, by embedding the principles of co-production.
 - Connecting the individual with community and broader society, particularly through voluntary organisations and community groups.
 - Working in a decision-focused, multi-professional and multidisciplinary way, including integration of teams working in health, social care and community development.
 - Securing investment from a variety of sources (statutory and non-statutory) through a multi-method, evidence-based approach.



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Thank you - any questions?

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