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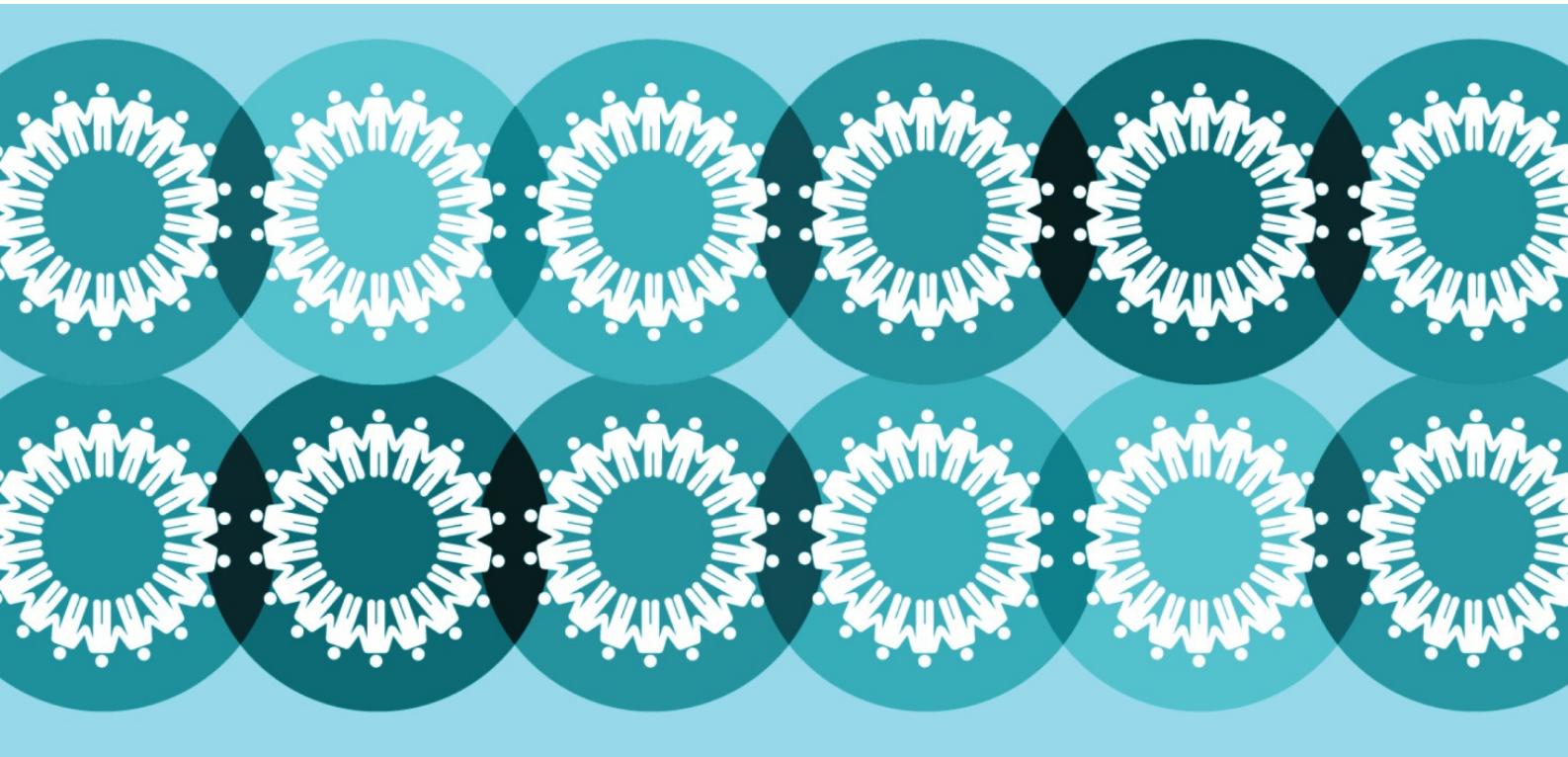
From dependence to independence: *emerging lessons from the Rotherham Social Prescribing Pilot*

Summary Report

December 2013



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

Summary Report

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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 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 a 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 patients, carers 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 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 support. 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.

Figure 1: The Rotherham Social Prescribing Model