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Involving the local voluntary sector in asset-based working: lessons from social prescribing 'plus' in Rotherham

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Introduction

- 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
- Social prescribing 'plus' as best practice in taking an asset-based approach to health
- Time for questions, debate, discussion etc

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 (VAR), since 2013; covering LTCs, mental health. Also evaluated 'Carer's Resilience Service' for Dementia Carers
  - Doncaster (SYHA), since 2015; Bradford (Hale) since 2017
  - Essex (County Council), since 2016
- 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

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

Challenges of social prescribing 'holistic'

- 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'
- In Rotherham 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 heath 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 and asset-based working

*"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)

SP plus as asset-based working?

- Key asset-based features of the SP 'plus' approach
  - Making the most of existing voluntary and community organisations - important to see the local VCS ecosystem as a 'health asset'
  - Building and sustaining the capacity of the VCS ecosystem to support social prescribing
  - Placing patients at the centre of the SP process - identifying their wants and needs and ensuring these can be met
  - Facilitating the progression of patients from supported participant to independent social action
  - Evaluating SP from the perspective of all key stakeholders: patients, public services, voluntary and community organisations
- The end goal: enabling medical professionals to support patients to "recognise and mobilise the assets and resources they have."

SP plus as good practice in asset-based working?

- Is SP plus good practice in asset-based working?
- Yes...Morgan (2014) sets out 5 principles to support the practical implementation of asset-based approaches

1. Prioritising person-centred approaches that emphasise building positive well-being and associated psychosocial resources.
2. Involving individuals and local communities effectively and appropriately, by embedding the principles of co-production.
3. Connecting the individual with community and broader society, particularly through voluntary organisations and community groups.
4. Working in a decision-focused, multi-professional and multidisciplinary way, including integration of teams working in health, social care and community development.
5. Securing investment from a variety of sources (statutory and non-statutory) through a multi-method, evidence-based approach.

SP plus as good practice in asset-based working

- Morgan's principles are mirrored by SP 'plus' in Rotherham

1. It is patient-centred and a key strategic priority for the CCG
2. Patients and communities are involved in every step of the process - opportunities: to engage in identifying needs, designing responses, and delivering services
3. Connecting patients to community based opportunities is at the heart of the SP 'plus model. Progression to independent participation and action encouraged and supported
4. SP 'plus' advisors are embedded in multi-disciplinary case management teams
5. It's evidence based and informed by ongoing evaluation; funding through health and social care integration (BCF)

Discussion: some things to reflect on...

- A chance for comment and questions
- Some reflections of my own:
  - Is Rotherham's model of SP 'plus' an example of good/best practice?
  - To what extent is it asset-based?
  - How could it be improved?
  - Can it be more effective than SP 'holistic' or lighter versions of SP (and how would we know)?
  - Why is SP 'plus 'not happening in many other areas?
  - Should SP 'plus' be the aspiration for every area in the UK?
  - If so, what are the barriers to this, and how can the be overcome?

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Thank you

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