Stronger Communities

Social Prescribing within whg

1. Executive Summary

1.1. Background

With a strong presence in Walsall and throughout the West Midlands, whg are committed to being a place-based housing association and anchor institution that builds homes and invests in communities where people can flourish and thrive. Great health and wellbeing are essential foundations for thriving and resilient communities and a successful economy, and whg are rightly proud to provide safe and secure homes, a key cornerstone for good health.

whg recognise the impact of other determinants of health for customers and communities, such as income and employment status, and the implications this has for tenancy sustainment and creating and sustaining resilient communities. As a member of the Walsall Together Board, and the local Integrated Care Partnership, whg contributes to the Resilient Communities workstream, which focuses on tackling health inequalities caused by the wider determinants of health.

There is a strong commitment from the whg Board and Group Executive Team to place health, wellbeing, and prosperity at the heart of the organisation and this is reflected in the whg Corporate Plan Successful People Successful Places

To support the delivery of the Corporate Plan, the whg Board approved a new health and wellbeing strategy, *The H Factor; Health, Hope and Happiness 2021 -24,* which has a specific focus on:

- Reducing Loneliness and Isolation
- Social Prescribing for those with the worst health and the least access to services
- Reducing the impact of poverty on children and families
- Enabling customers to age well and live their best life possible

whg know that they cannot achieve their ambitions alone and are therefore committed to working in partnership with others to make a positive lasting difference to the diverse range of people and communities they serve.

1.2. Context

whg has a long history of investing in health and wellbeing interventions, running a programme of initiatives since 2008 including: Walking Football Clubs, Breakfast Clubs in local schools, Community Gardens, Waste Away (weight loss programme) and Nifty over Fifty (encouraging movement in older life). However, a review in 2019 identified the limitations of these small-scale and isolated programmes and the potential impact that could be achieved by a joined-up programme of support. This led to the development of the social prescribing service, which whg launched in early 2020.

Within whg social prescribing is designed as intervention that formally links individuals with non-medical sources of support in order to improve their long-term health and wellbeing .

The service is intended to engage a broad user base, address local challenges and needs, support positive health and wellbeing outcomes, sustain tenancies and build stronger and more resilient communities.

Identified individuals can be referred into a social prescribing service by a whg link worker via a range of referral routes (e.g., primary care, secondary care, allied health, social care or statutory services)[1]. The link worker is a non-clinical person who excels at developing relationships so that people feel able to explain what is happening in their life. As you can see from the table below the majority of the referrals received were due to mental health and associated concerns such as anxiety and depression

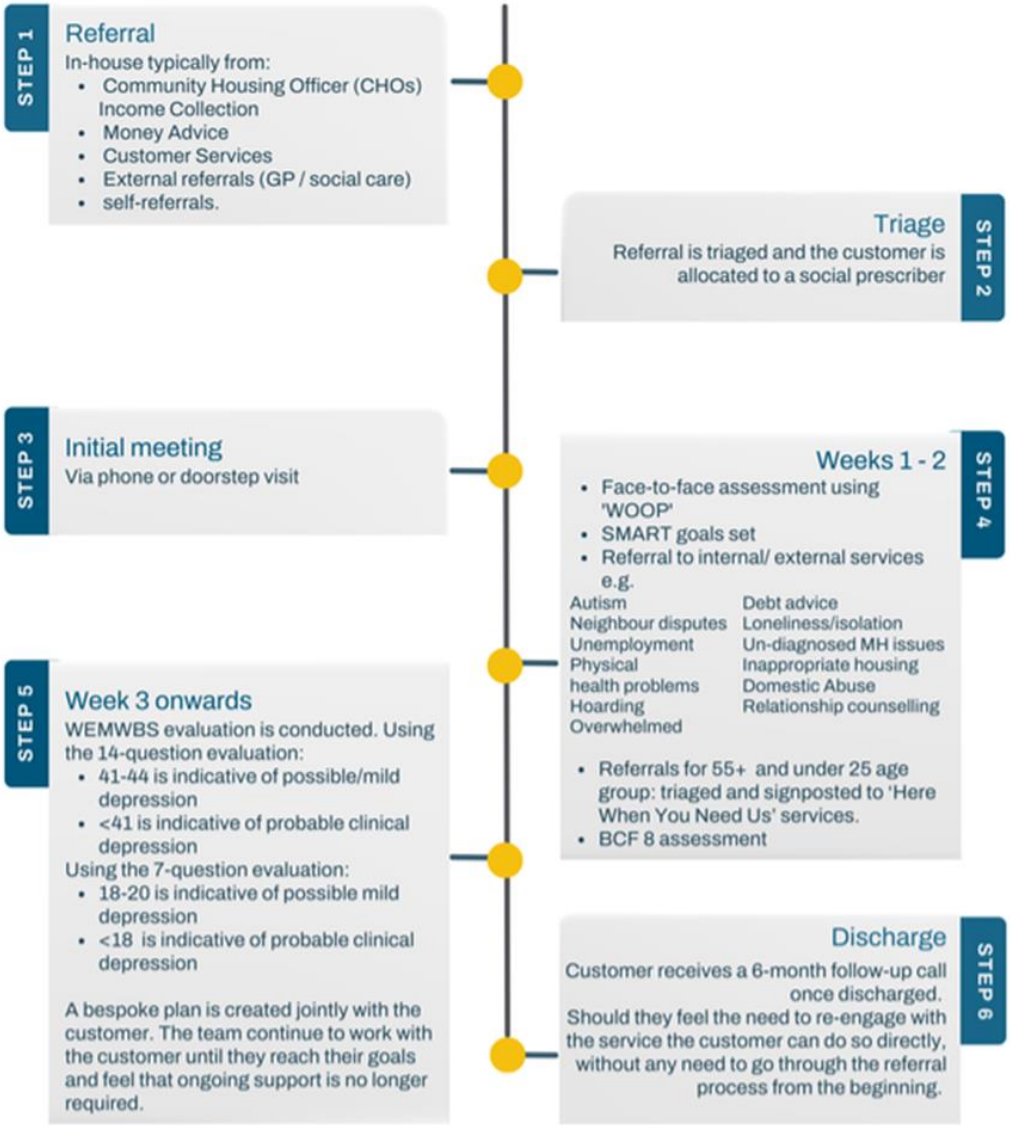
Reason for referral	**% of total customers engaged**
Loneliness/Isolation	27.80%
Mental health	24.19%
Low confidence & self-esteem	20.94%
Anxiety	19.49%
Poor life skills	9.03%
Depression	6.86%
Poor physical health	3.61%
Physical disabilities	3.61%
Low skills	2.89%
Domestic violence concerns	2.89%
Substance misuse	2.53%
Housing & homelessness	2.17%
Stress	1.81%
Debt	1.08%
General support	0.72%
Hoarding	0.72%
Ex-offender support	0.72%

An initial meeting with a link worker aims to uncover a person's preferences and unmet needs. The individual is then supported to access appropriate support, either internally via whg or by providing people with a **human bridge** to reach services that they may not be aware of or have previously struggled to access .

The majority of individuals have had several consultations with the social prescribing link worker before being ready to move onto a next step which can be taking part in a new experience or activity , volunteering, taking up new routines and behaviours and benefitting from services such as counselling or coaching .

The time spent building trust with the link worker is seen as a key part of the social prescribing intervention. Recognising that people's health and wellbeing are determined mostly by a range of social, economic, and environmental factors, social prescribing seeks to address people's needs holistically. It also aims to support individuals to take greater control of their health.

It has drawn on existing infrastructure and positioned community development and an asset-based approach as a core component of the work. In line with the objectives for whg's health and wellbeing strategy, *The H Factor,* the social prescribing service has focused on communities with significant levels of financial deprivation and heath inequalities.



The table above describes a typical pathway of participants

Recognising the need to evidence and evaluate the impact of the service in order to support service development and growth, in 2021 whg commissioned HACT (Housing associations' charitable trust) to work collaboratively to:

- Independently evaluate and quantify the impact achieved by whg's social prescribing service for service users and the organisation.
- Collate learning that can be used to shape service design, help embed a durable culture of continuous improvement going forward and make a case to local health partners for collaborative investment and partnership working.

Summary of findings

- A total of **277** customers engaged with the social prescribing service during the research reporting period (2021- 2022)
- The majority of service users identified as **female** (**70%**) and **White British**, (**88%**) and were aged between **26-35** and **36-45**.
- The average length of engagement was **145** days, with service users taking part in an average of **5** individual sessions.
- Just over a third of service users (**81)** were referred to a further support service to ensure their longer-term needs were addressed.
- The 'Family and Friends' test scored **100%** and service partners were happy with the service and their collaborative working with whg.

Service impact

- **Over 90% of services users reported positive change in WEMWBS scores** (**91.7%)** with **90.8%** reported a statistically meaningful positive change in their wellbeing. These scores are captured using WEMWBS survey questions.

    - Average WEWWBS score before engaging with the service was **33.4** and **49** after receiving support through the social prescribing service.
    - A large proportion of service users **(87%)** reported low levels of wellbeing prior to engaging with the service, compared to **28%** of service users who reported low wellbeing after receiving support.
      This highlights the need for the service and scope for further improvement in community and individual wellbeing within this population.

- A survey of a random sample of service users showed a significant self-reported impact of the Social Prescribing Service on **reducing pressures on primary care**, with **93%** reporting **a reduction** in the number of times they have needed to contact their GP. HACT has assessed the social impact of the social prescribing service and found the **total direct social value created by the projects was £1,923,146.**
- This is a result of: ***187*** *customers improving their SWEMWBS scores between the pre and post survey.*
- Although not the focus of the programme as people progressed and built mental and social capital, increased confidence and skills, people progressed into regular volunteering, employment, and accredited courses:

    - ✓ 22 customers progressed into employment
    - ✓ 36 customers took part in training to move them nearer to employment
    - ✓ 28 customers attended accredited training courses
    - ✓ 6 customers became regular volunteers within their own communities

Key headlines

Through this research, we have identified numerous strengths of the current approach:

Holistic support - the service is filling a gap in wellbeing support provision using innovative and holistic approaches to working with customers, contributing towards keeping people in their home

which has a huge benefit to their physical and mental health as well as engaging them in new opportunities such as training or work, which can lead to: lower likelihood of being in debt; reducing loneliness or isolation; being more effective parents; sustaining tenancies; and less need for more costly interventions within the health and social care system. The whg social prescribing service has had a life-changing impact, not only on those that engage with the service but importantly, on the wider family unit, the wider community and, as evidenced by self-report in the evaluation, the health and social care system by reducing the need for clinical services to intervene.

Effective service – feedback from both delivery partners and customers has been overwhelmingly positive highlighting the value of the service and how works extremely well to achieve desired outcomes. The impact of the service is evidenced through both quantitative and qualitative data and the Appendix has a case study to illustrate the holistic positive impact of the social prescribing service. One 60-year-old widower who was living alone and struggling to cope with the loss of his wife, is an excellent example of the holistic impact of the service. This individual went from feeling the despair of feeling that life no longer had any meaning and was in a state of contemplating suicide, to engaging with the social prescribing service and seeing his life turn around to such an extent that he had decided to become a volunteer with the team: “I can’t wait to give back to the community that has supported me so much.”

Person-centred & flexible service – the service provides targeted support and has excelled in creating trusting relationships with customers that forms the basis of the support. Social Prescribers are trained to empower service users to see themselves as active participants in their support leading to self-care.

Effective partnership working – the excellent relationship with partners is very clear to see, with one external stakeholder commenting that the service has “connected SO MANY dots” and enabled them to enhance how they work.

Convenience - the accessibility to an array of service offerings through the team as a single point of contact was highlighted as being a key feature of the success of the service as customers can receive something positive and constructive at the immediate point of engagement. People in need of support often feel that they are constantly moved from one service provider to another and are reluctant to trust new services or officers. The social prescribing service stops customers going through “revolving doors” and saves time for both the customer and whg colleagues. Customers who have never previously engaged with support services may trust their landlord with an initial referral as a customer already has a relationship with them. Referrals are effective partly because they are made by whg colleagues who already know residents. This also improves the relationship residents have with their landlord that may prevent future support needs or address them early.

1.3. Conclusions

HACT has been impressed by the hard work and dedication of the team successfully delivering services in what was, and remains, a challenging operating environment. The research shows that whg occupies a clear and a much-needed role in the local community as a support provider.

Overwhelming majority of comments in the interviews and survey were positive, with many customers referring to the positive atmosphere created by those providing the support.

During the evaluation reporting period, the service has **generated £1,923,146 in social value for the wider health economy in Walsall.**

The service has clearly improved the health and wellbeing of the people engaging within the service with many examples of service users developing the behavioural changes and resilience needed to cope with issues such as bereavement, debt, loneliness and isolation and domestic abuse all of which could possibly have ended up within primary care to manage. This is significant in an area such as Walsall, where health inequalities are persistent and unfair, sometimes leading to early death or a younger healthy life expectancy.

The research shows that whg occupies a clear and a much-needed role in the local community as a support provider. Social housing residents and other vulnerable individuals are still living in the aftermath of the pandemic and have an increased level of financial, employment, mental health and tenancy management needs. This situation is exacerbated by the depleted resources in other community services, including support provided by large national charities. whg, therefore, fills a gap in support services, providing impactful, consistent, and highly professional service that ranges from low-level support to more intensive 'hand-holding' support that aims to develop sufficient levels of confidence and independence.

HACT has identified one key opportunity and recommendation for the service **– expansion.** The Social Prescribing service at whg is oversubscribed and now has a waiting list. Given the impact this service has for service users, our main recommendation is therefore that whg explores funding opportunities with partners for this service to be expanded

The service is currently funded by whg and is over subscribed. These achievements have been delivered by a small team of **5 part time Social Prescribers and 1 full time Social Prescribing Manager.** We urgently require funding in order to sustain the service and upscale it so that we can reach an increased number of people. At present a small team of 4 part time social prescribers and 1 programme manager will engage with approximately 400 residents of which 350 will fully complete the programme . The cost of the programme for 12 months is approximately £200k . At present we have over 100 people on the waiting list for support .

Individuals low WEMWBS scores prior to intervention demonstrates that we are reaching the Core20 population and are therefore reducing health inequalities.

The most up to date performance of the service is detailed below:

whg SOCIAL PRESCRIBING Programme 2022.23

- **427 whg** customers' have received Social Prescribing support
- **247** Social Prescribing referrals received in 2022/23
- **127** current live cases
- **276** Customers to date have completed WOOP coaching plan.(Wish Outcome Obstacle Plan)
- **35** gained qualifications
- **20** long term unemployed people have moved into employment
- **9** people are now volunteering within their local community

The programme has been featured in a number of publications and was part of a submission to the HSJ awards in 2022 where the programme was shortlisted**:**

https://www.insidehousing.co.uk/insight/a-week-in-the-life-of-a-part-time-social-prescribing-link-worker-80604

To bring the programme to life please see below a recent case study.

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Case Study

"I had always been just a mum; it was time I did something for me. It means everything to get up each day and put a smile on someone else's face like someone did for me"

Initial WEMWBS 42

Final WEMWBS 66

Economically inactive 16 years

The power of Social Prescribing

From whg customer to whg colleague

Background In 2003 I became a whg customer. Over the course of the next 16 years I became a mom to 4 children. I never worked because I was in a difficult relationship and was told what to do and where I could go . All I did was take the children to and from school . I was very lonely . In 2019 things became so bad that I had to move away .

Support Offered Once I moved in whg asked me if I wanted a social prescriber to support me . My confidence was really low I felt I had nothing to offer and I knew I needed help . This is where the lovely Emily began to meet with me . At this stage I was just getting through each day looking after the kids and getting by . It wasn't really a life I was just going through the motions .I now know I was dealing with the damage caused by my relationship .

Approach WOOP Coaching Emily started off by meeting me and chatting and , getting to know me . She wasn't scary and I felt comfortable with her . Emily asked me some questions about my health and wellbeing, and I know my score was quite low (She had a wellbeing score of 42 and has a low score of 2 for confidence) The national score for wellbeing is 51 WEMWBS. Through weekly visits I worked with Emily to agree things I would try to do (WOOP Coaching model Wish Obstacle Outcome Plan) As the children were at school all day, I could have gone to work but I was scared to come off benefits . Although benefits are low you know you are going to get the money each month . If I got a job I didn't like or couldn't do it would mess up my money and I couldn't do that with my kids to look after . Emily asked me to think about volunteering .

Confidence building, I completed whg's Be A Better You course , this helps you to think about what you are good at and how to cope with difficult things . I loved it and now felt confident enough to become a volunteer and was trained as a befriender .

Giving Back I called people who felt lonely , often living on their own they loved a weekly chat with me . This could be a general chat that would last anything from 5 minutes to half an hour. I really enjoyed making calls to people each week I began to think differently about myself and really enjoyed helping people . People would share things with me and I had to get them help from different places .As part of the role I had training to improve my computer skills . I completed training in safeguarding helping me to understand when people are not safe and might need some help .

Knock Back I then applied for the Kindness Champion role with whg but was not successful . Emily encouraged me to learn from the interview and reminded me it was the first time I had applied for a job . The knock back made me more determined to go to work . I wanted my kids to be proud of me .

WEMWBS Wellbeing Score Emily did a second assessment and my score had increased to 66 which showed me how much I have changed .

Education I then began to volunteer at a local school and started college to improve my English and Maths .

Opportunities During this time Emily kept in touch with me and told me about the whg Health Champion jobs . whg organised a two-week pre work course which I completed .

Success I applied for the job and I cannot believe it, but I am now a whg Community Health Champion helping people in my own area . I cannot believe how my life has changed I look forward to everyday helping other people smile like Emily helped me . **Time spent on the programme 7 months ; contact continued 12 months**