Thriving Communities Programme Evaluation

Full Report

November 2021

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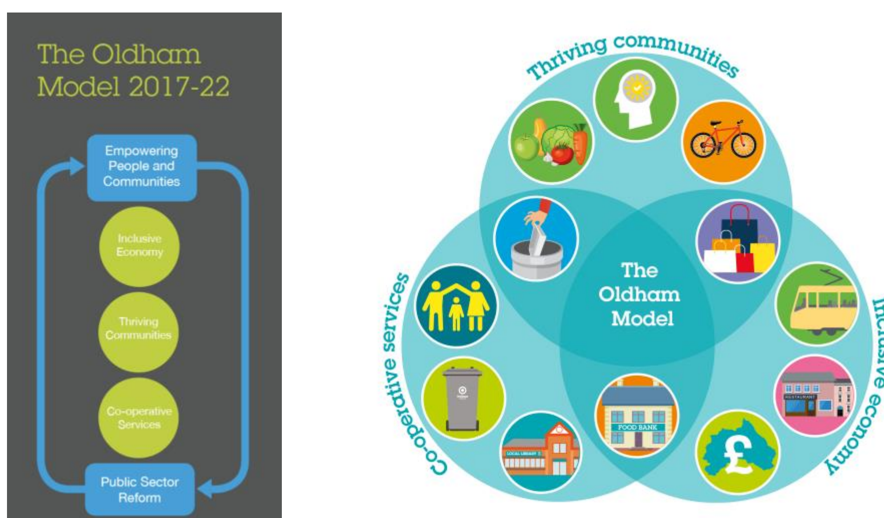
Section 1: Introduction and Context

The Thriving Communities programme is a flagship programme delivered by the Oldham Cares Partnership. The programme makes up part of Oldham Metropolitan Borough Council's (OMBC) 'Oldham Model'. The Council, and its partners, are committed to a co-operative future for Oldham where 'everyone does their bit and everybody benefits'. The Partnership's Oldham Plan 2017-22 sets out this model for delivering tangible and sustained change through an integrated focus on three core components:

- Inclusive Economy
- Thriving Communities
- Co-operative Services

The model is complemented and underpinned by a focus on two key enablers – public service reform and empowering people and communities.



In 2018, £2.69m was agreed to fund the Thriving Communities programme from Greater Manchester as part of the GM Health and Social Care transformation fund to support devolution. The aim was to accelerate the Thriving Communities element of the Oldham Model and deliver the common objectives of our health and social care integration.

Oldham Cares Partnership

The Oldham Health and Social Care economy has signed up to a new and ambitious vision for care which looks to 'see the greatest and fastest possible improvement in the health and wellbeing of the Borough's residents by 2020' and beyond.

Oldham Cares is focused on achieving positive outcomes for people with health and social care needs including:

- Supporting people to be more in control of their lives
- Having a health and social care system that is geared towards wellbeing and the prevention of ill health
- Providing access to health services at home and in the community
- Providing social care that works with health and voluntary services to support people to look after themselves and each other

Thriving Communities is one of the key workstreams of the Oldham Cares Programme. The Thriving Communities programme supports three other transformation themes within the Oldham Locality Plan and specifically delivers against GM Transformation themes;

- Radical upgrade in population health using the principles of early intervention and prevention;
- Transforming community-based care and support;
- Enabling better care.

The Thriving Communities Programme

The Thriving Communities Programme was established as part of the Oldham Cares transformation programme with the intention of creating the conditions for sustainable prevention, linking people into community capacity, social action and change. The Logic Model for the programme sets out the target outputs and outcomes:

Inputs	Activities	Outputs	Outcomes	Impacts (Transformation Themes)
Thriving Communities	Insight – community asset mapping, Thriving Communities Index, You & Your Community Survey	Thriving Communities Index & Nebula You & Your Community Survey Asset map of community organisations	Commissioners and policy makers are using intelligence & insight to support decision making and commissioning decisions	Increasing health and wellbeing Reduced Social Isolation Improved resilience and ability to take control of health and wellbeing
	Leadership and workforce development – asset/strength-based training developed and commissioned	Health & care professionals, and community members + partner organisations trained in use of asset- based approaches.	Residents experience asset-based and person-centred conversations with health and care professionals	Increasing capacity and sustainability within Voluntary, Community, Faith and Social Enterprise Sector
	Social action and infrastructure – social prescribing network, Social Action Fund, Fast Grants	Social Prescribing Network with underpinning targets Five Social Action Fund projects delivered 300+ Fast Grants projects delivered	Improved social connectedness and participation Increased community capacity and community development Increasing health & wellbeing	Reduced demand on health and care services
	Thriving Communities Hub – develop a strategy for sustainable investment in VCFSE sector	Attract external funding to deliver health & wellbeing outcomes Agreed strategic approach to public sector grant funding New approaches to commissioning with VCFSE sector developed	Increasing capacity in VCFSE sector to support residents through community led approaches Commissioning decisions redistribute resource to earlier upstream where the yield more benefit.	

Table 1.1: Thriving Communities Programme Logic Model

The Programme includes a number of Social Action and Infrastructure elements which support the delivery of these goals. The Social Prescribing Innovation Partnership, as well as the supporting investment into the VCFSE sector through Fast Grants and the Social Action Fund are at the core of this. These elements are interconnected in their delivery, and in demonstrating the whole system change required to impact through community driven early intervention and prevention.

Social Prescribing Innovation Partnership

A Social Prescribing network was commissioned for the borough by Oldham Cares through an innovation partnership from April 2019 to March 2022. This partnership is led by infrastructure organisation Action Together and comprised of Tameside, Oldham and Glossop Mind, Positive Steps, Age UK and Altogether Better.

The commissioning of this model reflected the recognition amongst partners locally that there was not a means for health and care professionals to effectively link patients to activity and support in their communities which could potentially benefit their health and wellbeing.

The Social Prescribing model is currently in operation across the whole Oldham borough, with Social Prescribing link workers aligned to each of the five Primary Care Network footprints. The model is based on using a strength-based approach to support improved self-care and people taking control of their health and wellbeing. Social Prescribing links workers with people referred into the service to identify their priorities for their health and wellbeing, to coordinate access to other specialist services if required (e.g. housing or welfare advice), and to link them with appropriate community groups and activities. The service is available to any resident of any age who would benefit from this.

As of 31st August 2021, the partnership had referred 1935 people to Social Prescribing services, with a growing and more complex demand since pandemic restrictions began to ease in Spring 2021.

Social Action Fund

The Social Action Fund made £850,000 available to fund five projects over a three-year period. Applications set out how their project would contribute towards:

- Tackling social isolation in Oldham
- Being transformational / innovative either in the delivery approach or the system change made within the VCFSE sector, with the public or enterprise
- Improving the mental health, physical health and wellbeing of people in Oldham
- Supporting a reduction in the pressure on health services
- Taking s strength-based approach to working with people

The Oldham Cares Commissioning Partnership Board awarded funds to five projects:

- **BAME Connect** is a new partnership bringing together five community groups to develop three neighbourhood hubs which have focused on reaching out to the isolated Pakistani and Bangladeshi communities. A programme of activities was delivered in consultation with residents based on community needs such as information and advice, physical

activity and wellbeing, befriending and peer support, food and nutrition, skills and education.

- **Wellbeing Leisure** partnered with community groups to provide physical activity and health and wellbeing opportunities. The project also offered opportunity for volunteers to learn skills and gain qualifications in health and fitness.
- **Oldham Play Action Group and Wifi NW** delivered all-age cookery courses, bringing children, parents, carers and older socially isolated people together to prepare and cook meals. The groups – run by Oldham Play Action Group (OPAG) and Wifi North West also encouraged people to engage in active physical play as well as organise community play street events to join neighbourhoods together.
- **Street Angels** has grown upon the already excellent work taking place in Oldham town centre on Saturday evenings and expanding into Friday nights. Teams of volunteers and medical staff are there to support those enjoying Oldham's nightlife providing a listening ear, first aid and basic medical treatment as well as making sure people get home safely. As part of the programme, an evening drop-in and hot meals were provided for people on the streets as well as daytime support from the Street Angels centre.
- **Groundwork** led a new partnership of organisations to bring a variety of new activities to venues across local communities, using growing and food to increase healthy outcomes and connectedness across the borough. As well as enjoying all that is on offer, participants were supported to develop, plan and sustain their own social groups around their hobbies and interests.

Projects were awarded funding between April and October 2019 and are due to conclude between April and October 2022. During the pandemic, projects had to adapt their delivery models, increasingly delivering virtual sessions as well as supporting the humanitarian aid response for Oldham.

Fast Grants

Fast Grants is a 3-year rolling programme of small grants of up to £500. These grants focussed on funding small scale community innovation by grass roots community groups and organisations, with the aim of being accessible and getting funding to community groups quickly. The investment totalled £180,000, with 133 grants awarded up to March 2020. From 2020/21, funds were rolled into the Action Together Covid-19 Recovery Fund. A further 68 grants have been awarded using Thriving Communities Fast Grants funds.

Funds were allocated to meet four priorities of the fund:

- Supporting the community to be fit and healthy
- Developing skills of local people
- Changing the area for the better
- Encouraging community participation

The Evaluation

Human Engine has been commissioned by Oldham Council to undertake a mixed methods evaluation of the programme. We are a Financial Times top-ranked management consultancy with specialisms in strategy, sustainability, people and performance. The company was founded by a group of former local government officers who think the public sector deserves better than it gets from traditional consulting firms – more human, more personal and more knowledgeable of the reality of delivering modern public services. We have worked with dozens of public sector organisations to help transform their strategies, operations and cultures to improve outcomes for local people and communities. We also work with councils and health organisations specifically supporting engagement and evaluation.

The Human Engine team is fully independent of the Thriving Communities programme and Oldham Council and has had no previous involvement in the design, development or delivery of the programme. The team worked with stakeholders across the Oldham Cares Partnership to undertake the evaluation but remained impartial regarding the outcomes, using evidence, knowledge and previous experience to complete a rounded and objective evaluation of the programme.

The evaluation has been completed using a mixed methods approach. This combined qualitative research and analysis to gather and understand stakeholders' experiences, perceptions and attitudes towards the programme, with quantitative research and analysis to determine if the target outputs and outcomes of the programme had been delivered. The evaluation framework asked four key questions:

- What is the impact for the people referred into Social Prescribing or funded activities?
- What is the impact on the public service system?
- What is the impact on local VCFSE sector?
- How effectively has the model been implemented?

The evaluation methodology is set out in further detail in the following section.

Structure of Document

This document offers a comprehensive evaluation of the Thriving Communities programme from its outset in April 2019 to the time of writing (November 2021). This timeline was agreed to enable the findings of this evaluation to influence and support decision making and budget setting for the new financial year from April 2022.

The document has six sections. Following this introduction and context, the paper sets out the methodology for the evaluation, describing the mixed methods approach and giving an overview of quantitative and qualitative techniques used. After this, the evaluation provides an overview of secondary research into evaluations of similar programmes to evidence where lessons learned were considered when completing the evaluation, and other lessons learned for OMBC and the partnership to consider moving forward.

The main body of the evaluation presents the primary findings and analysis from the evaluation and is divided into four parts; overview of the programme, Social Prescribing, Social Action Fund and Fast Grants.

Section five of the evaluation reflects on the evaluation questions set out in the evaluation framework, as well as the proposed outputs, outcomes and impacts from the programme's logic model. This leads to the final section that presents a series of conclusions and recommendations.

Section 2: Methodology

Evaluation Aims, Objectives and Process

The aims and objectives of the evaluation are four-fold:

- To demonstrate the overall impact of the Thriving Communities approach
- To demonstrate the deliverability and impact of the Social Prescribing network against agreed outcomes during the three-year delivery period, as well as the impact of the Social Action Fund and Fast Grants as significant investment in VCFSE network capacity alongside this
- To recognise the complexity of the system in which the Social Prescribing network is operating to generate learning from the Innovation Partnership model itself, beyond outcome targets, about the role of commissioning and investment in shaping the system to make the most impact through early intervention and prevention approaches
- To build up skills within the Oldham Cares system to support Oldham in developing a common approach to evidencing and evaluating the impact of early intervention and prevention approaches

The evaluation programme was a 9-month project with 3 phases:

1. Baseline analysis and report (February – April 2021)
   This report includes analysis of existing data, an overview experiences and perceptions of key stakeholders and secondary research to compile a gap analysis. This gap analysis highlighted where primary research will focus on during the following phases of the evaluation.

2. Primary data collection (April 2021 – September 2021)
   Undertaking data collection and analysis for areas identified in the gap analysis. This included comprehensive stakeholder engagement with 1:1 sessions, focus groups and workshops and surveys with stakeholders from across the Oldham system. Stakeholders included council officers from the programme team, social care, public health, libraries and communities teams, local VCFSE leaders and providers (including all Social Action Fund projects and Innovation Partnership organisations), NHS clinicians, managers and commissioners and, finally, service users and participants. In addition to this, extensive data analysis was completed on existing datasets collated throughout programme delivery.

3. Final Report (September 2021 – November 2021)
   This provides a full evaluation of findings with cross-analysis of quantitative and qualitative research and secondary research.

The Evaluation Framework

The framework sets out the intended impact and outcome for each of the evaluation question areas and the methodology or methodologies utilised to gather data (both primary and secondary).

Each phase of the evaluation focussed on answering the four research questions. These questions were used to shape the evaluation framework:

- What is the impact for the people referred into Social Prescribing or funded activities?
- What is the impact on the public service system?
- What is the impact on local VCFSE sector?
- How effectively has the model been implemented?

Evaluation Question	Intended Impact / Outcome	Proposed Methodology
1. What is the impact on people referred into SP or participants in community activities?	• Improved individual wellbeing • Improved resilience & ability to take control of own health and wellbeing • Community based activities & support are effectively integrated into new models of care • Reduced demand on wider public service system	• ONS4 &/ SWEMWBS Wellbeing scale - track change over time • Qualitative engagement with residents, e.g. case studies, interviews Focus: ▪ impact on health & wellbeing ▪ impact on broader outcomes e.g. housing, employment, debt ▪ experience of service / activities
2. What is the impact on the public service system?	• Reduced demand on health & care system • Reduced demand on wider public service system	• Quantitative analysis of key health service data (GP attendances, A&E attendance, non-elective bed days) – track change over time • Return on Investment model
3. What is the impact on the local VCFSE sector?	• Increased capacity and sustainability within VCFSE sector • Community based activities & support are effectively integrated into new models of care	Qualitative engagement with VCFSE organisations/groups working within SP model e.g. interviews, case studies. Focus: ▪ impact on organisations ▪ inward investment ▪ volunteer capacity & skills development ▪ sustainability
4. How effectively has the model been implemented?	Clinicians, care professionals and residents are able to access community based and person-centred activities & support for their patients / themselves Community based activities & support are effectively integrated into new models of care	Qualitative engagement and observations with key system stakeholders e.g. commissioners, staff, GPs, VCFSE sector, programme board. Focus: ▪ innovation partnership as a tool for commissioning ▪ critical enablers e.g. partnership, workforce, ▪ embedding in local context Qualitative and quantitative analysis to determine public value delivery

Table 2.1: Evaluation Framework

A Mixed Methods Approach

Evaluating programmes without a clear, direct financial or numerical benefit is notoriously difficult and previously completed evaluations of Social Prescribing and community-led programmes are testament to this. For initiatives funded by public money, this is particularly complex as there must be consideration of public value during evaluation. This evaluation has been completed using a mixed methods approach to combine the 'facts and figures' of quantitative data with stakeholder experiences, perceptions and attitudes through qualitative data.

This mixed method approach also combines primary and secondary research. Primary research has been collected throughout the delivery of the programme and the Human Engine team have undertaken fieldwork to complement existing primary data. Secondary data from existing Oldham Council datasets (such as Thriving Communities Index) as well as nationally recognised datasets and methodologies have also been utilised.

Qualitative Research Overview

Primary qualitative research and fieldwork undertaken by Human Engine collected approximately 1,243 unique data points. This does not include existing case studies collected by the programme team and projects that contribute further qualitative data to the evaluation. In total, it is estimated there is in excess of 2,000 unique qualitative data points. This gives a diverse and extensive breadth of insight and feedback from stakeholders to understand their experiences and perceptions of the programme and its delivery workstreams.

Over 100 1:1 interviews were completed by Human Engine with stakeholders from across the system. Stakeholder groups are outlined below:

- Oldham Council senior leaders
- Oldham Council officers in service areas (public health, social care, communities, libraries)
- Oldham Council Thriving Communities Programme officers
- Oldham Council commissioners
- Health clinicians
- Health managers
- Health commissioners
- Local VCFSE leaders
- Local VCFSE providers (including all Social Action Fund projects and Innovation Partnership organisations)
- Fast Grant recipients
- Project site visits

In addition to this, surveys were undertaken with project participants and service users to understand the impact initiatives have had on their lives, the benefits and challenges participants faced and recommendations on what residents would like to see beyond the timeline of the Thriving Communities funding.

Throughout the evaluation, qualitative research is presented for different stakeholder cohorts to enable direct comparison of experiences between different groups:

- **Strategic** – feedback from leaders and individuals in strategic roles across the system
- **Delivery** – feedback from individuals in operational positions and delivery partners
- **Partner services** – such as social care, health and public health who may not be directly involved in service delivery but are a beneficiary of the outcomes of the Thriving Communities programme
- **Service Users** – groups and individuals who have accessed services through Thriving Communities

Case studies collected by project delivery teams throughout the programme also play a key part in evidencing the qualitative impact of the programme. Case studies feature throughout the evaluation.

Quantitative Research Overview

To support the qualitative research, quantitative research and analysis has been completed to evidence the 'facts and figures' associated with the programme. This combines data collected throughout delivery of the programme, such as Social Prescribing referral data and monitoring reports from projects, and surveys completed by Human Engine. It is estimated that approximately 75,000 quantitative data points have been analysed as part of the evaluation.

Addressing the Impact of the Coronavirus Pandemic

The Coronavirus pandemic has, inevitably, had a fundamental impact on the outcomes of the programme, the partnership organisations and the people it set out to support. Discussed throughout the evaluation will be instances where the programme has been flexible to adapt to changing circumstances throughout delivery to support both partner organisations and grant recipients and residents during the pandemic.

Due to the very essence of the services provided as part of Thriving Communities, the projects did not stop when the UK entered lockdown in March 2020. In fact, in most cases, their work increased to reach and support those in most need across the borough. The evaluation has taken this into account. When projects applied for funding from the programme, each completed a comprehensive application process, including presenting performance metrics and financial tracking. Clearly, from March 2020 priorities changed and the evaluation has worked with projects to identify work they were doing to reach agreed targets before March 2020, as well as assessing how each workstream has been flexible to continue to deliver services during the pandemic.

Section 3: Literature Review and Best Practice

Evaluation of projects of this kind is notoriously difficult. A common reason for this is that there is no established financial measurement model for the identified benefits. Specifically focussing on Social Prescribing, there is broad and wide-ranging literature on approaches to evaluating the impact of projects, with national and international examples.

Literature Review

Approaches to Evaluation

The NHS Social Prescribing and Community-Based Support summary guide offers an insightful perspective of what successful Social Prescribing looks like for the people utilising the service, for communities (including VCS) and, most crucially, for the wider system. The latter of these is of particular interest and relevance to the research questions of the Thriving Communities evaluation, and outlines success indicators including partnership approaches to commissioning, link workers typically hosted by VCFSE sector, clear and easy referral process with encouragement for self-referral and sustainable development of community groups (NHS, 2020).

Previous research has demonstrated the benefits of Social Prescribing fall into six topic areas – physical and emotional health and wellbeing; behaviour change; cost effectiveness and sustainability; capacity to build up the voluntary community; local resilience and cohesion; and tackling the social determinants of ill health (University of Westminster, 2016). Table 3.1, below, demonstrates each of these with the associated specific benefits.

Benefits of Social Prescribing go beyond simply the individual and consistently show to have an impact on the wider system, including healthcare professionals, healthcare providers, local authorities and the local economy – through an increase in skills and lifestyle changes associated to employment.

Physical & emotional health & wellbeing	Cost effectiveness & sustainability	Builds up local community	Behaviour Change	Capacity to build up the VCS	Social determinants of ill-health
• Improves resilience • Self-confidence • Self-esteem • Improve modifiable lifestyle factors • Improve mental health • Improve quality of life	• Prevention • Reduction in frequent primary care use • Savings across the care pathway • Reduced prescribing of medicines	• Increases awareness of what is available • Stronger links between VCS & HCP/bodies • Community resilience • Nurture community assets	• Lifestyle • Sustained change • Ability to self-care • Autonomy • Activation • Motivation • Learning new skills	• More volunteering • Volunteer graduates running schemes • Addressing unmet needs of patients • Enhance social infrastructure	• Better employability • Reduces isolation • Social welfare law advice • Reach marginalised groups • Increase skills

Table 3.1: Associated Benefits of Social Prescribing

It is suggested that some often-quoted approaches and methodologies to evaluation have proven more difficult to use in practice. For example, Bromley's Social Prescribing model evaluation included the use of Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) to document service user outcomes, however it was found to be *'too unwieldly'* and Newcastle's Social Prescribing initiative recorded that *'most participants did not fill it out'* (GMCVO, 2019).

Linking to this, a 2019 study attempted to evaluate the likelihood of enrolment, engagement and continued participation in Social Prescribing initiatives by testing 'if-then' statements with service

users. The research found that key success indicators relied on initiatives that were delivered by a leader who was skilled and knowledgeable and that repeat participation relied on a change in the service user's condition or symptoms (Husk, et al., 2019).

Social Prescribing is also used as an alternative to medical prescriptions across the world. Australia and New Zealand are regularly used as case study examples for public management, policy and service initiatives. Research that focussed on the role of Social Prescribing for mental health illnesses in Australia identified that emergency departments were often the first point of call, with those attending emergency departments for mental health needs equating to 3.4% of all emergency visits. Of these, 60.7% of mental health emergency department visits were resolved without admission (Aggar, et al., 2020). *Plus Social* was Australia's first mental-health specific Social Prescribing programme. The research tracked participants across a number of indicators, including quality of life, welfare needs, psychological distress, loneliness and economic participation. The research showed participants who completed the programme experienced 'significant improvement in physical and psychological quality of life, health satisfaction and self-perceived health status' (Aggar, et al., 2020). In addition, the evaluation identified the 'golden thread' between *Plus Social* and local and national health policy and suggested the approach can be included within the current funding model and is scalable across the Australian context (Aggar, et al., 2020).

Cost Effectiveness of Social Prescribing

The long-term cost effectiveness of Social Prescribing is not yet clear. However, short-term cost-effectiveness has been estimated for the Doncaster's Social Prescribing programme. It used cost-utility analysis to evaluate cost-benefits of patient's improvements in health-related quality of life. The programme estimated that every £1 spent on the service produced more than £10 of benefits in terms of better health (Sheffield Hallan University, 2016).

Another study undertaken into the cost effectiveness of Social Prescribing reviewed evaluations of 15 Social Prescribing programmes in the UK from between 2000 and 2016. Of these, the study suggests many were small scale and 'limited by poor design and reporting' and none were of sufficient quality to reach a strong or evidenced cost-effective recommendation for their use (Bickerdike et al., 2017). However, one before-and-after study undertook a cost-benefit analysis using estimated input costs and benefits derived from 12-month outcome data obtained for 108 patients referred to Social Prescribing. A total NHS cost reduction of £552,189 was generated by multiplying the estimated per-patient cost reduction by the total number of referrals – an approximate saving of £5,112 per service user (Bickerdike et al., 2017). Their conclusions showed that 'current evidence fails to provide sufficient detail to judge either success or value for money' (Bickerdike et al., 2017).

This brief literature review shows experiences of implementing and evaluating Social Prescribing programmes in different contexts. It highlights the inconsistency of approaches to evaluation and difficulty at determining cost effectiveness and value for money.

The rise (and rise) of community-led service delivery

Community-delivered public services are not a new phenomenon but there has been a rise in community delivery throughout the last decade. This can be ascribed to the impact of austerity and the localism agenda on local public services. 'Community localism' is defined as 'the devolution of rights and support directly to citizens and communities to allow them to engage in decisions and action' (Evans, et al., 2013, p. 403). A key strength of community localism is that it gives ownership to citizens and uses local knowledge of citizens to identify and solve issues in their community (Evans, et al., 2013). In addition, community localism can support the delivery of targeted and more locally specific public services by increasing responsibility and prioritising community interests and the collective voice.

Research has shown that this has brought a series of benefits to services delivered by communities and voluntary groups – including the increasing importance of co-production principles in service design and delivery, improvements in community capability and capacity, improving relationships between local authorities and the community sector and better system and partnership working (Mills, 2019). We have, of course, seen this play out to a greater extent since the onset of the Coronavirus pandemic, with local authorities across the country pooling resources together and working hand-in-hand with the community sector to lead the response to the pandemic in their locality.

This leads to the idea and definition of *public value* as a means of assessing the benefits of community-led service provision. Public value has three pillars: (1) that public managers create value by achieving their mandated purpose efficiently and effectively, (2) that public value can be captured through analytic techniques, such as programme evaluation, and (3) that public value can be measured in the satisfaction of stakeholders and customers (Moore, 1994). Using this definition as part of the framework for evaluation of Thriving Communities can give structure to assessing the benefits of the less-tangible elements of the programme, through understanding their impact on stakeholders and the effectiveness of programme delivery.

Case Studies

Focussing specifically on the practical delivery of projects, the following sets out evaluations and progress reports of four Social Prescribing projects from across the UK. The breadth of case studies is vast, some dating back to the late 2000s. With the complex and ever-changing structure and approaches to delivering these services, case studies identified have been delivered within the last five years. This improves the likelihood that learning can be transferable to the Thriving Communities model in Oldham.

Greater Manchester Centre for Voluntary Organisation (GMCVO)

In 2019, the GMCVO published its findings from a 4-month review of Social Prescribing across GM, with a 'deep dive' into provision in Salford. The conclusions showed a series of enablers that were present in successful Social Prescribing initiatives (GMCVO, 2019):

- Holistic, joined up services, including greater awareness of the outcomes, meeting with people where they feel comfortable and removing 'time-bound' intervention
- Regular communication and good and maintained relationships between partners

- High levels of flexibility and free from top-down constraint
- Long term resources and secure staffing, including ensuring career pathways and Continued Professional Development opportunities
- Up to date resource mapping
- Building an evidence base, including balancing the projects needs and outcomes of all partner organisations – it was identified that there were clear differences to the projected outcomes from NHS, VCFSE and local authority partners

In addition to this, the report found three key challenges for the delivery of Social Prescribing (GMCVO, 2019):

1. Rapidly changing commissioning models
2. Insecure funding for the VCFSE sector and/or funding for the link worker position
3. A lack of streamlined communication between GP and link worker (for example, there was rarely a single data system of point of access to records)

Connect for Health – Leeds South and East CCG

Connect for Health was launched in 2016 for everyone over the age of 14. Led and funded by Leeds South and East CCG, it included partnership with Leeds City Council. One key project of Connect for Health was the Patient Empowerment Project (PEP) which focussed on people with one or more of: depression, diabetes, COPD or cardiovascular disease. In the first two years of the project, 1,411 people were referred to PEP with *'generally positives outcomes'*. These included 70% of referrals engaging with the service on more than one occasion, a statistically significant improvement in health and wellbeing, a reduction in 'did not attend' medical appointments post-intervention and a reduction in primary care appointments (Ridge & Weir, 2018).

The success of this programme as a proof of concept led to the implementation of *Linking Leeds* – a Social Prescribing integrated network, bringing together partners across the city, including primary care, CCGs, local authority and VCFSE partners.

East Merton Social Prescribing Pilot

This small-scale pilot in London Borough of Merton worked with two GP surgeries in February 2017. The pilot aimed to promote self-help, social engagement and resilience to its population in East Merton by (1) providing a model of service delivery that connects medical care with local resources; and (2) establishing a collaborative pathway between the primary care and voluntary and community services (Healthy Dialogues Ltd, 2018). During the 12-month pilot phase, 316 patients were referred to the programme.

The pilot delivered a reduction in GP appointments in 3-months post intervention of 33% and a reduction 6-month post intervention of 11%. In addition, there was a recorded 6-month A&E appointment reduction rate of nearly 50%, although this was of a smaller cohort of 43 patients (Healthy Dialogues Ltd, 2018).

As of April 2018, the identified successes of the pilot programme led to the Merton Social Prescribing partnership rolling the referral process to nine of the borough's GP surgeries.

Bristol SPEAR

Whilst many of the case studies discussed above focus on medical outcomes for service users (reduced A&E admissions and GP appointments), Bristol Social Prescribing for Equality and Resilience (SPEAR), funded by Bristol City Council, seeks to focus on the wider determinants and benefits associated with health and wellbeing. The programme is a partnership of community anchor organisations that 'develop connections and builds trust with local residents from different communities and backgrounds' (Bristol SPEAR, 2019). The programme 'uses a holistic Social Prescribing approach, working alongside people to address the wider issues that are negatively impacting on them and then together find the spark inside' (Bristol SPEAR, 2019).

The locality-based initiatives have focussed on the most deprived communities in Bristol that are within the England's top 10% of areas of multiple deprivation. The programme delivers a range of activities such as cooking classes, physical activities, art and crafts, social support groups, volunteering opportunities and practical advice and guidance to empower people to build resilience in managing their life and lifestyle.

To date, Bristol SPEAR state that 88% of people who have accessed their services self-report an improvement in their wellbeing.

Section 4: Findings and Analysis

In addition to data collected throughout programme delivery, primary data collection and fieldwork was undertaken between April and September 2021. This included completing comprehensive stakeholder engagement with 1:1 sessions, focus groups and workshops and surveys with stakeholders from across the Oldham system. Stakeholders included council officers from the programme team, social care, public health, libraries, and communities' teams, local VCFSE leaders and providers (including all Social Action Fund projects and Innovation Partnership organisations), NHS clinicians, managers and commissioners and, finally, service users and participants.

This section presents the findings and analysis of the evaluation, including both qualitative and quantitative data. The section has four sub-sections:

1. Overview of the programme:
    a. Thematic Analysis
    b. Return on Investment modelling
2. Social Prescribing
    a. Qualitative feedback from each stakeholder group
    b. Quantitative analysis of Social Prescribing cohort
    c. Case studies
3. Social Action Fund
    a. Qualitative feedback from each stakeholder group
    b. Quantitative analysis of SAF cohorts
    c. Case studies: Project review
4. Fast Grants
    a. Qualitative feedback from each stakeholder group
    b. Quantitative analysis of Fast Grants awarded
    c. Case studies: Project review by priority

Overview of Programme

Thematic Analysis

Throughout the engagement programme, five key themes emerged from stakeholders. The themes had both positive and negative connotations but together represent the thoughts, experiences and perceptions of the 100+ stakeholders who participated in the evaluation.

Theme 1: Defining 'Thriving Communities'

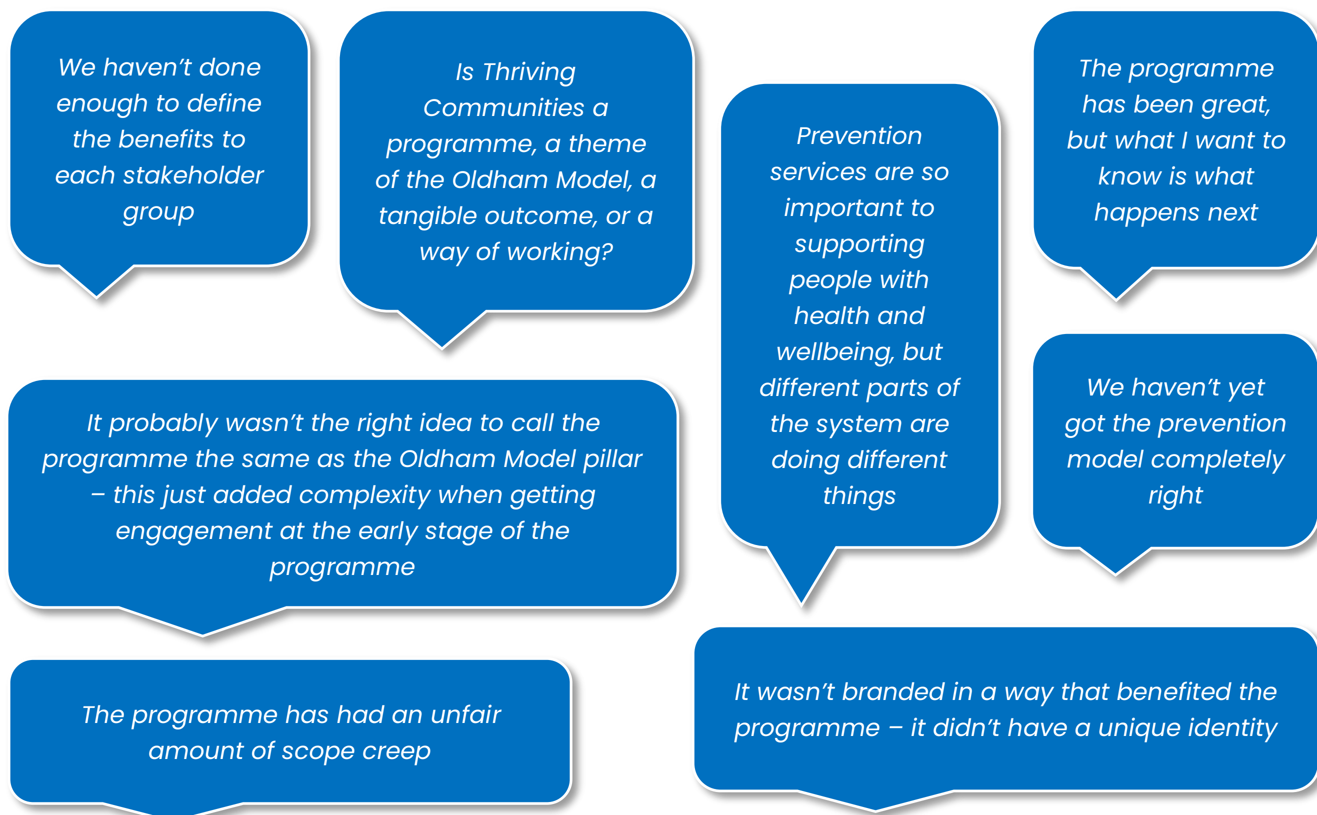


Figure 4.1: Defining Thriving Communities Qualitative Data

Throughout engagement, it became clear that there was an inconsistency when defining 'Thriving Communities' across stakeholder groups. Where some saw Thriving Communities as a programme of work, others suggested it to be a way of working or the end goal. This inconsistency is likely to have had an impact on different stakeholder group's perceptions of the programme's success.

The complexity and diversity of stakeholders engaged in the programme has led to a differing understanding of the desired outcomes and benefits of the programme. Naturally, health and social care colleagues focussed on the impact Social Prescribing has had on the health and wellbeing of participants and highlighted tangible health outcomes as the key measures. Conversely, colleagues across the VCFSE identified the benefits grant funding had had on building community capacity, connecting people throughout the community, and supporting people through crises to a position of self-supporting. Strategic stakeholders regularly asked, *'what next?'* for Thriving Communities. Other stakeholders prioritised benefits around cashable savings or cost avoidance that the programme had delivered to the Oldham system.

Stakeholders agreed that there is not a single joint approach to prevention services in Oldham. Whilst Thriving Communities has begun this discussion, the system is yet to have one approach. Some stakeholders suggested that this could have impacted on buy-in to the programme from

different parts of the system with some seeing Thriving Communities as a means to an end and others viewing it as an end in itself – a prevention model for the borough.

The programme has, as one stakeholder put it, *'tried to be all things to all people all of the time'* and this could have impacted on the clarity of the benefits that have been delivered. When identifying reasons for this, the impact of the pandemic and changes to delivery methods is likely to have been the primary contributor to the inconsistencies. The programme (both in terms of projects / service provision and funding) was widely considered to be critical to the borough's response. However, changing priorities during the second half of the programme could have impacted on the benefits, outcomes and perceived purpose of the Thriving Communities.

Theme 2: System-wide Value of VCFSE in Service Delivery

Figure 4.2: System-wide Value of VCFSE in Service Delivery Qualitative Data

There was unanimous feedback from across stakeholder groups and programme workstreams that Thriving Communities has transformed the local VCFSE sector, increasing its influence, value and impact on the Oldham system and the people it supports. Networking groups, such as the Social Action Fund Community of Practice, have highlighted the role and value of community groups and enabled groups to collaborate to deliver targeted services for group participants.

Many view the VCFSE sector as a major stakeholder in the system and this is evidenced by VCFSE stakeholders involved in decision making boards and partnership groups. This raises the implications of the programme on future commissioning approaches. There is an opportunity to learn lessons from the successes of the VCFSE sector in service delivery and the role the sector has had in service delivery as part of the pandemic response and bring these into public service commissioning practices in the future. This should include determining the role of consortium bids, high value grant funding or outcomes-based commissioning to the sector.

This increased role of the VCFSE sector has led to increased capability – from leadership to networking, or partnering to deliver a more diverse offering to participants. This can, and should, lead to the sector having a greater influence in strategy at both a local authority and system-wide level. Enabling the sector to engage with system-wide strategic decisions can support the borough's ambition to join up prevention and intervention services and minimise complexity of the commissioning landscape.

The value placed upon the sector suggests that Thriving Communities has been influential in embedding the role of VCFSE sector within Oldham as a locality and given a platform for the VCFSE sector to continue to grow its role as a provider of prevention services.

Theme 3: Approaches to Partnership and System Working

Figure 4.3: Approaches to Partnership and System Working Qualitative Data

Experiences and perceptions of the impact of Thriving Communities on partnership and system working are the most diverse and mixed of all themes. Broadly, stakeholder experiences show that partnerships between organisations and day-to-day delivery of projects have been integral to the success of projects. However, the project has not influenced system-working partnership outcomes at a strategic level to the extent it had hoped.

Partnership working across the VCFSE sector and between groups facilitated by the programme has created resilience across the sector and enabled communities to diversify delivery and continue to deliver services throughout the pandemic. This includes cross-project delivery and quick and easy sign-posting of service users to other services. In addition, it was consistently reported by stakeholders across all cohorts that the partnerships built from the programme meant Oldham were able to respond quickly and decisively at the beginning of the pandemic.

Despite successes in partnership working, there was feedback from stakeholders that the programme could have done more to integrate into social care services and health partners earlier in delivery. Stakeholders put this down, in part, to awareness and understanding of partners' responsibilities in programme delivery, including the differences between prevention services offered from different organisations. This, again, points towards complexities caused by differing prevention models across the Oldham system.

Theme 4: Community Capacity and Capability

Figure 4.4: Community Capacity and Capability Qualitative Data

A key outcome for the programme was to increase community capacity and capability to deliver prevention and intervention services. Stakeholder perceptions and experiences suggest that the programme has been broadly successful at delivering this. Thriving Communities has been the catalyst for Oldham Council to reduce control on service delivery and place trust in the community sector to deliver services. A combination of a commissioned arrangement and grant funding has enabled the VCFSE sector to progress initiatives and services that target delivery to the right people.

Capability

Case studies demonstrate examples of groups supporting people to move from crisis to self-supporting. In addition to this, there is evidence to demonstrate 'pure' deflections from social care to Social Prescribing, indicating the initiative's capability to reduce demand on social care services and support higher need cases.

Many stakeholders referenced the networks and collaboration that have enabled projects to deliver a wider range of services. Projects also referenced improved capability, upskilling and shared learning that has been critical to identifying, bidding and winning new funding streams. Furthermore, projects demonstrated how funding had been used for workforce development to increase capability of teams to deliver services to communities.

Trust and partnerships between organisations has been key to stakeholders having positive experiences and perceptions of improved capability.

Capacity

Community capacity has increased through direct financial investment in community projects and there is evidence of the programme supporting groups to move towards sustainability once the programme comes to an end. However, there is a concern that there may be a reduction in volunteers that has been built during the programme. Groups collectively experienced an uplift in volunteer numbers during the pandemic as people had more free time and had a desire to support their communities. As the borough and its communities moved out of each lockdown, volunteer numbers reduced, and this is likely to have a knock-on effect to the capacity of service delivery.

Theme 5: Governance and Administration

Figure 4.5: Governance and Administration Qualitative Data

An important element to successful delivery of complex programmes is a strong programme management office and governance arrangements. This theme was regularly discussed by all stakeholder cohorts, covering three key topics: (1) data; (2) commissioning and funding, and; (3) programme governance.

Data

Stakeholders often cited data sharing with mixed experiences. There is an ongoing issue with data sharing across the Oldham system, which partners continue to seek solutions for. Being unable to see the whole picture of an individual's context and needs means each part of the system is unable to best deliver person-centred care and reduces the opportunity for genuine joint working or sign-posting.

More positively, stakeholders were complimentary of the Thriving Communities Index and the role this has and can continue to play to target services at ward and neighbourhood level.

Commissioning and funding
There were consistent and positive experiences of the commissioning process undertaken for the Social Prescribing Innovation Partnership, with stakeholders commenting that it has '*changed the landscape of the commissioner-supplier relationship'*, with co-design and co-production key to this. It is important that the positive lessons learned from this experience are taken forward as part of future commissioning activity.

Stakeholders commented that the grant funding process was often complex and lengthy, however the benefits of this has been the development of skills and knowledge to complete other local and national funding applications. This has resulted in groups bidding and winning bids, contributing direct inward investment into the borough. In addition, community groups felt that the Thriving Communities application was a two-way process, with Oldham Council demonstrating how they are able to support successful applications to deliver their projects.

Programme Governance
Stakeholders were positive about the role of the programme team and programme governance throughout delivery. The partnership board and other partnership groups were well attended and partners completed highlight reports and review documentation – none of which was felt to be over-burdening. The programme team and Oldham Council were also praised by delivery partners for the flexibility granted at the outset of the pandemic to redistribute or repurpose funding to respond to the changing need of their communities.

Financial Return on Investment Modelling

Creating a financial return-on-investment for programmes of this kind is notoriously difficult. Previous approaches were discussed in the literature review and best practice section.

Combining data gathered throughout the programme and primary research throughout the evaluation, we are able to estimate a financial ROI based on a series of values to create a formula that presents the impact of every £1 spent on social prescribing.

The programme data shows that Social Prescribing is projected to deliver 300 'pure' deflections from social care services each year. A 'pure' deflection is defined an individual previously on the social care waiting list whose needs were supported by Social Prescribing and no longer required input from social care services. This gives an average value of £1,844 spent on Social Prescribing per social care deflection.

When comparing this figure to the average cost of low-level care packages to support people with domestic tasks, errand running or companionship, national market figures suggest average annual costs of between £3,640 and £7,280 for this care. (UK Care Guide, 2021; Elder, 2021; Hometouch, 2021; Home Care, 2021).

The table below outlines ROI, based on different estimated hours of care per week.

Hours of low-level care per week	Total Annual Cost	ROI ratio (social prescribing to social care)
3.5 (half an hour per day)	£3,640	1 : 1.97
5 (1 hour per weekday)	£5,200	1 : 2.82
7 (1 hour per day)	£7,280	1 : 3.94

Table 4.1: Programme ROI Modelling

For every £1 spent on Social Prescribing services there is potential cost avoidance of between £1.97 and £3.94 in social care.

This implies potential cost avoidance for social care services of between £1.092m and £2.184m per year*

*This potential cost avoidance figure is determined by the number of social care deflections who are no longer awaiting a Care Act assessment. This is caveated with the assumption that the 300 referrals from social care to Social Prescribing would have received some social care package. However, if not all referrals would have qualified, there is still substantial cost avoidance for social care. The following table assesses potential cost avoidance based on percentage of 'pure' deflections being eligible of a social care package. This approach has been taken as data on Care Act eligibility of referrals was not captured. It is recommended that this data is captured as part of future social prescribing services to more accurately determine ROI to social care.

% of Social Prescribing deflections from social care that would be eligible for social care package if Care Act assessment was completed	Low End Cost Avoidance	High End Cost Avoidance
1%	£11k	£22k
5%	£55k	£110k
10%	£110k	£220k
25%	£273k	£546k

This table acknowledges the range of cost avoidance to social care is likely to be much lower than the headline figure but there is clear opportunity to reduce demand on the Care Act assessment process, and in so doing, avoiding costs of undertaking Care Act assessments for 300 people per year, supporting people sooner through Social Prescribing services and, at least, delaying their requirement for higher need, higher cost services.

The ROI analysis focussed on social care as this was this was the most accurate and valid data available, with limitations in primary and secondary health data due to it being self-reported. Based exclusively on social care deflection data, the breakeven point for Social Prescribing would be approximately 25% of social care referrals being eligible for a care package under the Care Act but being supported through Social Prescribing as an alternative. However, this does not account for the long list of other financial benefits that can be aligned to the work of the programme:

- Inward investment into the borough from grant funding awarded to VCFSE groups who have been part of Thriving Communities and wish to grow projects beyond their current reach. Groups often quoted their application and involvement in Thriving Communities as the catalyst for growth
- Full or part time jobs created in the VCFSE sector providing local jobs for local people
- Increase in trained volunteers across Oldham VCFSE sector, improving resilience and sustainability across the sector. Social Action Fund projects have reported training of over 100 new volunteers
- Jobs and volunteer numbers contributing to overall increase in community capacity
- Skills development and workforce development of VCFSE sector to improve capability of community groups to deliver services in new and engaging ways, as well as supporting increasingly complex referrals
- Demand reduction and cost avoidance for the wider public service system in Oldham, such as housing and welfare support – service user data from across the programme shows high numbers of referrals of people needing support and achieving positive outcomes

In addition to this, the programme data shows that Social Prescribing is projected to deliver 1,671 'positive' engagements with service users throughout the programme (up to March 2022). This gives a value of £993.41 per positive engagement. A positive engagement is defined by referrals whose needs have been met, referrals who are waiting for their 3-month review or have been signposted to the correct service. This figure is demonstrably lower than any provision of care and support from public services. Community-based support offers an ROI and a success rate that prevents service users relying on higher need, higher cost services and enabled people to move away from acute crisis to self-supporting.

Research from Sheffield Hallam indicates total ROI for Social Prescribing could be as much as 1:10. The ROI put together for Thriving Communities has relied predominately on social care deflections data, which already evidences a considerable ROI. Combine this with the additional financial ROI above, social ROI harnessed from the programme, including community cohesion and qualitative benefits would result in a considerably higher ROI for Thriving Communities.

Social Prescribing

A Social Prescribing network was commissioned for the borough by Oldham Cares through an innovation partnership from April 2019 to March 2022. This partnership is led by infrastructure organisation Action Together and comprised of Tameside, Oldham and Glossop Mind, Positive Steps, Age UK and Altogether Better.

The commissioning of this model reflected the recognition amongst partners locally that there was not a means for health and care professionals to effectively link patients to activity and support in their communities which could potentially benefit their health and wellbeing.

The Social Prescribing model is currently in operation across the whole Oldham borough, with Social Prescribing link workers aligned to each of the five Primary Care Network footprints. The model is based on using a strength-based approach to support improved self-care and people taking control of their health and wellbeing. Social Prescribing links workers with people referred into the service to identify their priorities for their health and wellbeing, to coordinate access to other specialist services if required (e.g. housing or welfare advice), and to link them with appropriate community groups and activities. The service is available to any resident of any age who would benefit from this.

As of 31st August 2021, the partnership had referred 1935 people to Social Prescribing services, with a growing and more complex demand since pandemic restrictions began to ease in Spring 2021.

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Qualitative Analysis

Qualitative research will be presented by stakeholder cohort to enable direct comparison of experiences and perceptions between different groups.

- **Strategic** – feedback from leaders and individuals in strategic roles across the system
- **Delivery** – feedback from individuals in operational positions and delivery partners
- **Partner services** – such as social care, health and public health who may not be directly involved in service delivery but are a beneficiary of the outcomes of the Thriving Communities programme
- **Service Users** – groups and individuals who have accessed services through Thriving Communities

Strategic

Figure 4.6: Social Prescribing Strategic Stakeholders Qualitative Data

Delivery Partners

Figure 4.7: Social Prescribing Delivery Partners Stakeholders Qualitative Data

Partner Services

Figure 4.8: Social Prescribing Partner Services Stakeholders Qualitative Data

Service Users

Figure 4.9: Social Prescribing Service User Stakeholder Qualitative Data

Qualitative feedback from each stakeholder group was, broadly, very positive. Strategic stakeholders identified the impact the innovation partnership had had on partnership working across the system, with one suggesting it to be *'the best example of partnership working anywhere I have worked'*. Others did identify areas of complexity and the need for a single wide prevention approach – a common discussion point throughout the evaluation process.

The positive experience is supported by external recognition, as the innovation partnership won the Community Category at the European Innovation in Politics Awards in December 2020. Delivery partners also recognised the benefits of the partnership approach, notwithstanding issues that arose when launching the service. Organisations say their collaborative approach leads to each member of the partnership delivering their best services and many also commented that the partnership approach had also improved relationships with other system organisations, such as the council and primary care.

'The Social Prescribing Innovation Partnership is recognised for bringing a more holistic, long-term approach to health and well-being, reducing social isolation, strengthening community ties, and helping the people of Oldham access the support they need'

European Innovation in Politics Awards 2020

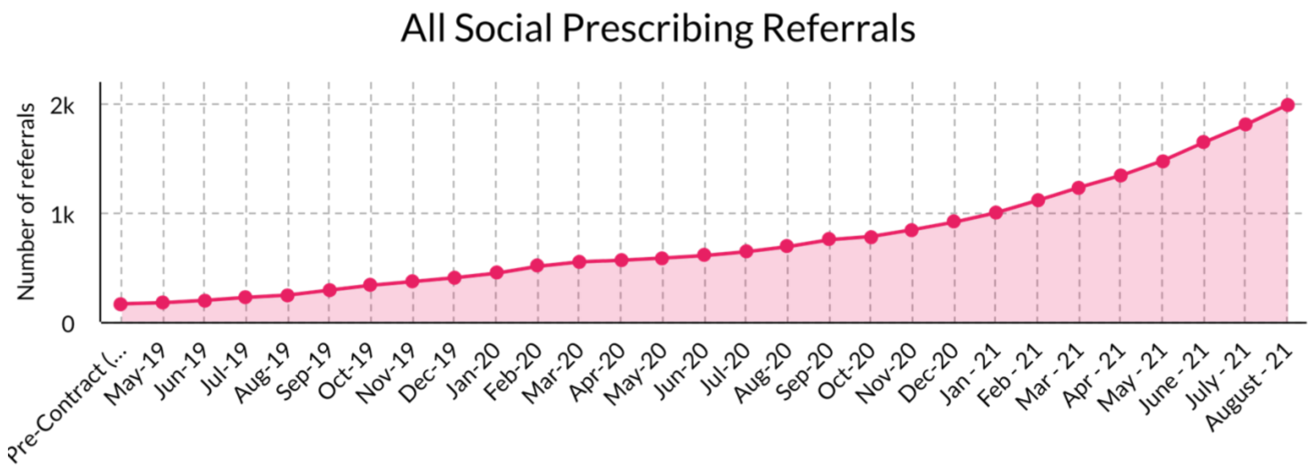
A survey of service users highlighted the benefits Social Prescribing had had on their lives, with many suggesting that engagement in the service had '*got my life back on track*', '*turned my life around*' and '*given me the confidence to move forward with my life*'. Others also stated that it '*increased awareness of my community, what was out there and gave me some connection'.* When asked to reflect on the challenges of accessing the service or improvements they would like to see, many cited the need for more face-to-face meetings, which are now being delivered (much of this feedback was collected during the coronavirus pandemic). The main challenge stated was from service user who struggled to communicate when English is not their first language. The innovation partnership has a number of bilingual social prescribers and this was reflected in some of the feedback, with one service user saying, *'the biggest challenge was the language barrier as I thought I will not be able to communicate in English and was low on confidence, but the SP worker was bilingual and I could communicate easily'.*

Quantitative Analysis

The Social Prescribing dataset shows information for all those who engaged with the service between pre-contract and the end of August 2021. The dataset was anonymised before analysis was undertaken, with no identifiable personal data included.

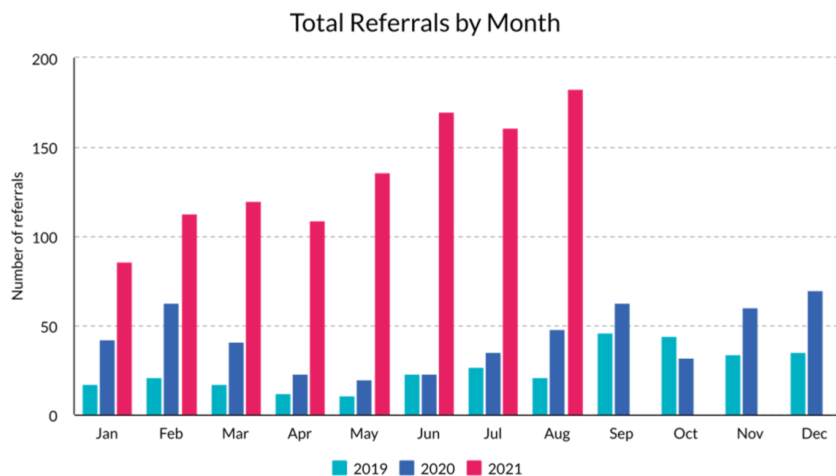
Number of Referrals

Throughout this period of data collection, 1,935 individuals had engaged with the service. As demonstrated in graph 4.1, this number rose steadily until January 2021, where it has since accelerated – doubling in the eight months from January 2021 – August 2021.



Graph 4.1: All Social Prescribing Referrals

This demand is shown to a greater extent by graph 4.2, below, showing the peak on demand for services during 2021 – a vast increase from previous years. Additional link workers have been recruited in 2021 to support this demand however this spike sees the Social Prescribing service nearing capacity, as well as dealing with increasingly complex cases.



Graph 4.2: Total Referrals by Month

Reason for Referral

When the primary reason for referral was analysed, Loneliness and Social Isolation was accountable for almost a quarter of all referrals. As table 4.2, below, shows, the top 4 reasons for referral made up 59.1% of referrals.

Reason for Referral	% of Total Cases
Loneliness and Social Isolation (All variations)	24.7%
Housing (All variations)	14.3%
Mental Health (All variations)	12.8%
Benefits Advice (All variations)	7.3%

Table 4.2: Reasons for Referral

To understand this further, reasons for referral were divided into social, economic and health factors. There was a total of 46 reasons for referrals listed. Interestingly, despite top reasons for referral making up 59% of all referrals, there is broadly an even split between social, economic and health factors once all reasons are accounted for. This shows that, beyond the top 4 reasons, there has been a wide range of referrals supported by the Social Prescribing Innovation Partnership. Examples of each factor include:

Social

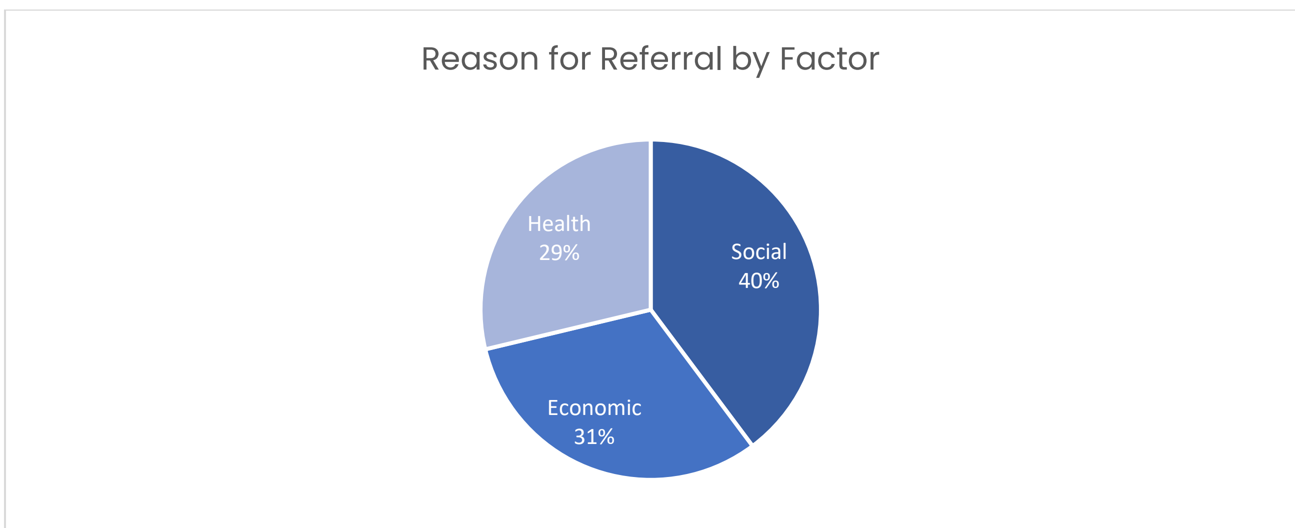
- Loneliness and Social Isolation
- Low Self-Esteem
- Befriending

Economic

- Housing
- Benefits or Financial Advice
- Employability and Employment Support

Health

- Mental Health
- Physical Inactivity
- Support with Chronic Conditions

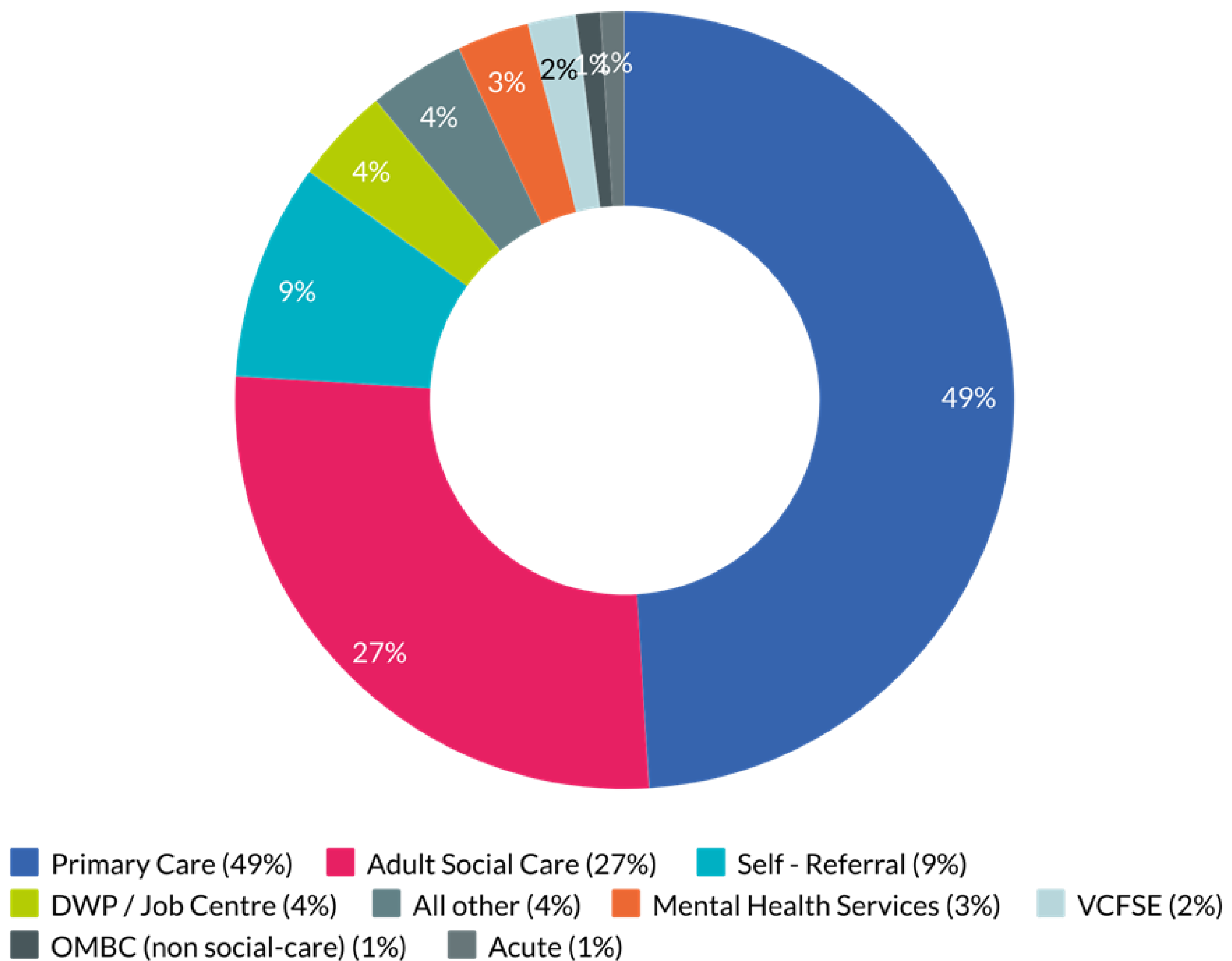


Graph 4.3: Reasons for Referral by Factor

Source of Referral

The main source of referral has been from primary care (49%). Combining this with adult social care (27%), the two sources constitute three quarters of referrals into Social Prescribing. This is of interest as the data suggests there to be a joined-up approach between health, care and Social Prescribing, despite the thematic analysis and qualitative analysis suggesting cross-system working was not as strong as it could be.

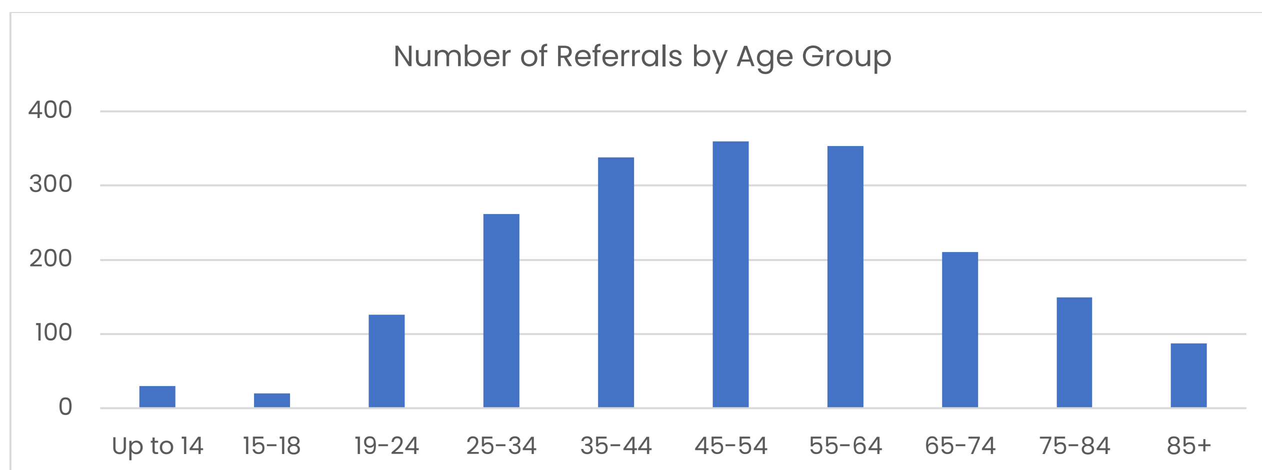
This could be due to investments made in infrastructure to ease referrals between systems. The Elemental Social Prescribing system went live in January 2021 with intensive training for users and communication and engagement with partner organisations. This now enables referrals direct from EMIS and GP practice engagement and training has been undertaken to improve ease at which the workforce can use the system. The primary care referral number has risen from 22% in September 2020, evidencing the impact of better joined up systems.



Graph 4.4: Source of Referral

Referrals by Age Group

Dividing referrals by age group identified a peak in referral number for older working aged groups. Over half of all referrals (1,051) were for people aged between 35-64.



Graph 4.5: Source of Referral

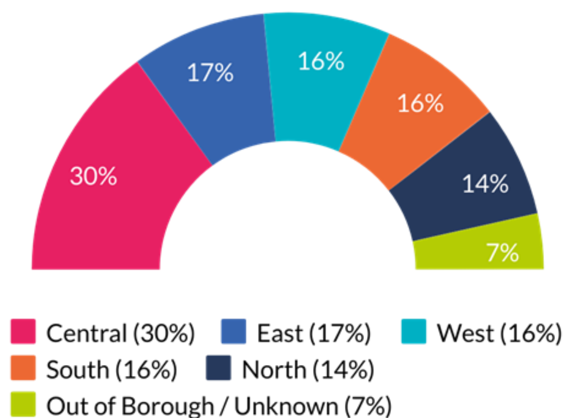
Breaking down referrals by age group further evidenced a consistency in the most common reason for referrals. Loneliness and social isolation was recorded as the most common reason for referrals across every age group and housing was the second most common reason for referral for every age group other than under 14 (physical activity). Whilst this may come as no surprise as these are the two most common reasons for referral overall, it is interesting that there is a gradual and consistent rise by age group of the percentage of cases loneliness and social isolation accounts for from 25-34 age group upwards. This peaks for over 85, in which loneliness and social isolation accounts for almost half of all referrals.

Age group	Most Common Case	Cases	As a % of all cases	Second Most Common Case	Cases
Up to 14	Loneliness and Social Isolation	13	43%	Physical Inactivity	4
15 to 18	Loneliness and Social Isolation	3	15%	Housing	3
19 to 24	Loneliness and Social Isolation	23	18.20%	Housing	16
25 to 34	Loneliness and Social Isolation	35	13.30%	Housing	34
35 to 44	Loneliness and Social Isolation	54	15.90%	Housing	50
45 to 54	Loneliness and Social Isolation	71	19.70%	Housing	41
55 to 64	Loneliness and Social Isolation	72	20.30%	Housing	20
65 to 74	Loneliness and Social Isolation	59	28.00%	Housing	22
75 to 84	Loneliness and Social Isolation	61	40.90%	Housing	15
85+	Loneliness and Social Isolation	40	45.90%	Housing	8

Table 4.3: Referrals by Age Group and Most Common Reason for Referral

Referrals by Oldham District

Almost a third of all referrals were from Central district of Oldham. Beyond this, there was an even divide of referrals from the other four districts. Using the factors (social, economic and health) outlined above, interestingly health factors were the main factor for referral in the central district despite being the lowest overall factor. For all other districts, social factors were the main factor for referral.



Graph 4.6: Referrals by District

Central Oldham was also the most common district for referrals by age group for five out of the ten age group cohorts.

Age Group	Most Common District
Up to 14	Out of Borough / Unknown
15 to 18	Central Oldham
19 to 24	West Oldham
25 to 34	Central Oldham
35 to 44	Central Oldham
45 to 54	Central Oldham
55 to 64	Central Oldham
65 to 74	West Oldham
75 to 84	East Oldham
85+	East Oldham

Table 4.4: Most Common District for Referral by Age Group

Referrals by Year and Quarter Breakdown

To understand the impact of the pandemic on referral rates and reasons for referral, referrals were broken down by quarter for each year since the beginning of the programme. The most common reason for referral remains consistent from 2018-2021, loneliness and social isolation as the most common for all but one quarter (Q2, 2018, Physical Inactivity). Throughout 2018, 2019 and Q1 2020, there are various second and third most common reasons for referral (Mental Health, Physical Inactivity, Employability, Financial Advice). Housing only features in the top three reasons for referral in two quarters prior to the pandemic (Q3 2019 and Q4 2019) despite being clearly the second most common reason for referral overall.

As the pandemic began (Q2, 2020), the second and third most common cases quickly align to economic factors (Housing, Financial Advice, Welfare Support) and these have remained consistent since.

2018 Referrals by Quarter

Quarter	Total cases for Quarter	Most Common Case	No of Cases	2nd Most Common	No of Cases	3rd Most Common	No of Cases
Q1	6	Loneliness and Social Isolation	4	Physical Inactivity	2	N/A	0
Q2	16	Physical Inactivity	6	Loneliness and Social Isolation	4	Employability	2
Q3	39	Loneliness and Social Isolation	14	Mental Health	9	Physical Inactivity	8
Q4	37	Loneliness and Social Isolation	11	Mental Health	10	Financial Advice	4
Total cases for year	**98**						

Table 4.5: 2018 Referral Breakdown by Quarter

2019 Referrals by Quarter

Quarter	Total cases for Quarter	Most Common Case	No of Cases	2nd Most Common	No of Cases	3rd Most Common	No of Cases
Q1	55	Loneliness and Social Isolation	18	Mental Health	8	Housing	7
Q2	46	Loneliness and Social Isolation	11	Financial Advice	6	Mental Health	6
Q3	95	Loneliness and Social Isolation	38	Mental Health, Wellbeing	16	Housing	8

Q4	113	Loneliness and Social Isolation	48	Housing	22	Mental Health	10
Total cases for year	**309**						

Table 4.6: 2019 Referral Breakdown by Quarter

2020 Referrals by Quarter

Quarter	Total cases for Quarter	Most Common Case	No of Cases	2nd Most Common	No of Cases	3rd Most Common	No of Cases
Q1	146	Loneliness and Social Isolation	40	Mental Health	26	Wellbeing	17
Q2	66	Loneliness and Social Isolation	20	COVID-19	10	Financial Advice, Welfare Support	8
Q3	146	Loneliness and Social Isolation	47	Housing	32	Financial Advice, Welfare Support	15
Q4	162	Loneliness and Social Isolation	19	Housing	10	Financial Advice, Welfare Support	6
Total for year	**520**						

Table 4.7: 2020 Referral Breakdown by Quarter

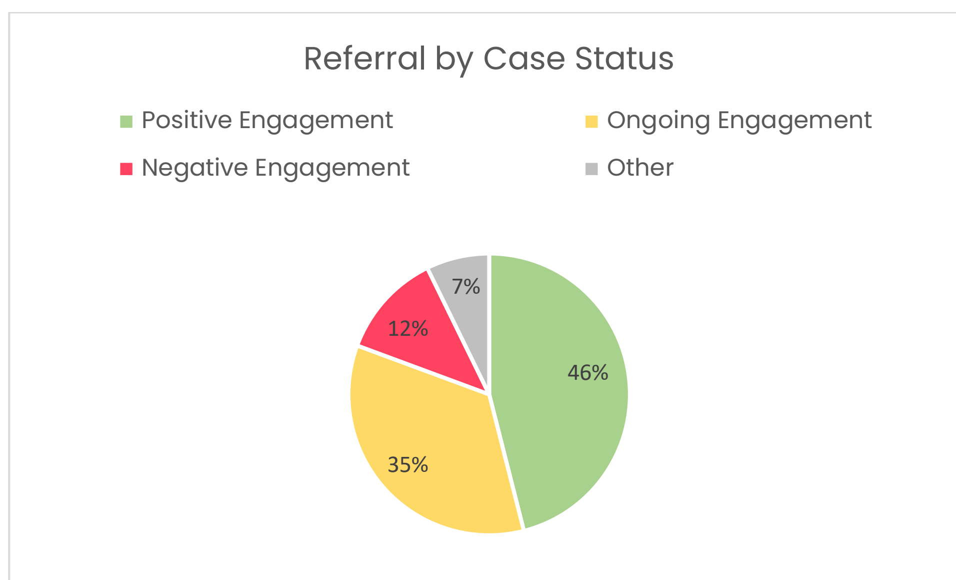
2021 Referrals by Quarter (to date)

Quarter	Total cases for Quarter	Most Common Case	No of Cases	2nd Most Common	No of Cases	3rd Most Common	No of Cases
Q1	319	Loneliness and Social Isolation	69	Housing	44	Benefits Advice, Housing	10
Q2	414	Loneliness and Social Isolation	45	Housing	38	Benefits Advice	11
Q3	274	Loneliness and Social Isolation	49	Housing	19	Mental Health Issues	9
Total for year to date	**1,007**						

Table 4.8: 2021 Referral Breakdown by Quarter

Referral by Case Status

As a method of understanding the impact, outputs and outcomes of Social Prescribing referrals, analysis was completed to determine the breakdown by case status. Each referral is given one of 20 different case status description. These have been divided into 'positive', 'ongoing', 'negative' or 'other' and an overview has been provided below.



Positive Engagement	882
Ongoing Engagement	663
Negative Engagement	232
Other	139

Graph 4.7: Referral by Case Status

As of August 2021, of all cases, nearly half (46%) have been rated as positive. This means either the individual's needs had been met, they were awaiting a three-month review or had been signposted to a different service. If 'ongoing engagement' is removed, positive engagement accounts for 70% of referrals that have been closed.

Only 12% of cases have been a negative engagement. This includes individuals who disengaged after having started Social Prescribing or those who were unable to be contacted once referred.

- A positive engagement is defined as referrals whose needs have been met, referrals who are waiting for their 3-month review or have been signposted to the correct service
- An ongoing engagement is defined as new referrals, those currently engaging in the service or awaiting service
- A negative engagement is defined as referrals who were previously attended and have now disengaged or referrals whose link workers and now unable to contact

ONS4 Wellbeing Scores

To further our understanding of impact, outputs and outcomes of Social Prescribing, those who engaged with the service were asked to complete a simple four-question survey when beginning the engagement and three months after using the service. This methodology is ONS4, created by the Office of National Statistics and regularly used as a method of measuring wellbeing scores.

As of August 2021, 216 participants had completed the pre and post engagement questionnaire. This gives us a 95% confidence level and a 6.3% margin of error.

Question	Average Score Pre-Engagement	Average Score Post-Engagement	% change
Q1 Life Satisfaction	3.2	4.6	↑ 14%
Q2 Worthwhile	3.8	5.1	↑ 13%
Q3 Happiness	3.5	5.1	↑ 16%
Q4 Anxiety	5.0	4.2	↓ 8%

Table 4.7: ONS4 Wellbeing Scores for Social Prescribing Service Users

The wellbeing scores show that there was an improvement across all four questions, with Q1-3 scores increasing and Q4 score decreasing (participants are feeling less anxious). Combining this statistical examination of wellbeing outcomes with qualitative feedback from participants supports the conclusion that Social Prescribing has successfully delivered a range of key, positive outcomes.

What is confidence level?
The probability that your sample accurately reflects the attitudes of your population. The industry standard is 95%.

What is margin of error?
The range that your population's responses may deviate from your sample's.

Health Statistics

The evaluation set out to understand changes to participants health appointment numbers across three statistics: GP appointments, A&E visits, non-elected hospital bed days. Data is self-reported and asked participants to share the number of each of the above they had had three months prior to engaging with Social Prescribing services and three months after having finished engaging with a service.

In total, there were 249 participants who have given data for pre and post engagement. This gives us a 95% confidence level and a 5.8% margin of error. However, these statistics are presented with

a caveat that numbers are self-reported, rather than actuals. This reduces the accuracy of the data but, nonetheless offers a guide to one of the key outcomes for the programme.

The data shows an overall increase in GP appointments and A&E visits and a reduction in non-elected hospital bed days. However, once broken down, it shows a more positive impact. For these who had had at least one GP appointment prior to engaging in Social Prescribing, 68 out of 126 had fewer appointments, with 37 remaining the same. Only 21 (16%) had more appointments. There is a similar trend across A&E visits and non-elected hospital bed days. These numbers are too small to put forward an evidence-based conclusion but offer a guide to the health impact of Social Prescribing.

GP Appointments

Number of Appts	Number of Appts (No of people) 3-months prior engagement	Number of Appts (No of people) 3-months post-engagement	Notes
0	0 (123)	97 (123)	
1-3	151 (115)	126 (115)	Fewer = 57 Same = 37 More = 21
4-6	41 (10)	17 (10)	A decrease in appts from all service users
7+	8 (1)	0 (1)	A decrease in appts from all service users
TOTAL	**200 (249)**	**240 (249)**	

Table 4.8: GP Appointments for Social Prescribing Service Users

A&E Visits

Number of Visits	Number of Visits (No of people) 3-months prior engagement	Number of Visits (No of people) 3-months post-engagement	Notes
0	0 (232)	29 (232)	
1	10 (10)	3 (10)	Fewer = 8 Same = 1 More = 1
2	6 (3)	0 (3)	A decrease in appts from all service users
3	9 (3)	0 (3)	A decrease in appts from all service users
4	4 (1)	0 (1)	A decrease in appts from all service users
TOTAL	**29 (249)**	**36 (249)**	

Table 4.9: A&E Visits for Social Prescribing Service Users

Non-Elected Hospital Bed Days

Number of Bed Days	Number of Bed Days (No of people) 3-months prior engagement	Number of Bed Days (No of people) 3-months post-engagement	Notes
0	0 (238)	19 (238)	
1	8 (8)	0 (8)	Fewer = 8
2	4 (2)	0 (2)	A decrease in appts from all service users
3+	14 (1)	0 (1)	A decrease in appts from all service users
TOTAL	**26 (249)**	**19 (249)**	

Table 4.10: Non-Elected Bed Days for Social Prescribing Service Users

In addition to this health data, the innovation partnership has been able to track social care deflections data based on referrals from the MASH between January 2021 and August 2021.

Number of referrals from MASH	Number referred directly back to ASC / MASH	Number of referrals joint working	Number of 'pure' deflections of out ASC / MASH
284	3	80	201

Table 4.11: Social Care Deflections for Social Prescribing Service Users

These numbers are critical to understanding the direct benefit of Social Prescribing to social care. Out of 284 referrals from social care, 201 (70.7%) were supported by Social Prescribing and no longer required input from social care services. In addition to this, a further 80 (28.1%) referrals were 'twin tracked', with Social Prescribing supporting the individual's needs whilst they were awaiting social care support. Only 3 (1.2%) of referrals were too complex for Social Prescribing to support.

This results in an average of 25 'pure' deflections per month or 300 per year.

This referral rate is positive for a number of reasons:

1. It demonstrates successful joint working and referral pathway between social care and Social Prescribing
2. It demonstrates a successful 'front-door' assessment by social care and MASH teams to determine which cases can be supported by Social Prescribing
3. It demonstrates real cost avoidance (time and money) that the wider public service system gains by having a flourishing Social Prescribing network

Social Prescribing Case Studies

Soreya's Experience

Soreya is an English and Urdu speaking single parent and mother of four children. One of her son's requires constant care relating to mood and behaviour due to autism. Soreya was previously married and in a psychologically abusive relationship. She has been long-term unemployed and lost self-confidence and esteem. She has also been socially isolated and lonely which has exacerbated her low-mood and depression. Soreya has a long-term health condition which restricts her movement and causes her pain. She was referred by her Physiotherapist for support.

Her key concerns related to her son's behaviour and education, her social isolation, her depression, her feeling of hopelessness for the future, lost confidence and her well-being.

The social prescriber offered a full assessment, listening to Soreya's priorities around her family issues and her social and well-being needs. Initially addressing issues relating to her son's education, the social prescriber was able to reassure Soreya of his progress and ability in class through reports from his teachers. Staff contacted Soreya and provided full reports which relieved her of the fears and anxieties she had been experiencing, which has also been affecting her sleep.

The social prescriber explored carer support and agencies relating to autism and shared this with Soreya. They also discussed personal skills and abilities inspiring Soreya to consider a life-plan for her future to motivate her, drawing on her skill base and experience. This included building an ambition to develop a business using her make-up and beauty training. Soreya wants to combine this with current interests in Floristry.

Soreya and the social prescriber also worked together to explore practical online courses to boost health and well-being and researched friendship groups and other avenues to meet new friends and potential partners.

Soreya is currently sleeping better and feeling hopeful about her future. She feels reassured about her son's education and knows that she can speak to staff about any concerns. She also feels supported and more aware of additional help.

She is feeling more able to manage her depression as she feels that she has a life for herself to look forward to. She also says this support is restoring her belief that "there are good, kind people out there." She hopes to build on her personal development plan and is looking forward to meeting new people and developing new skills. The social prescriber is continuing to support Soreya through this transitional period.

She has since begun a course in Floristry at her local Lifelong Learning Centre. She also has an appointment with the Team at Oldham Leisure Centre to commence "Exercise on Prescription" and has joined a local woman's social group.

Anne’s Experience

Anne was referred to Oldham Social Prescribing in August 2019 by her daughter as she was struggling with confidence to go outside due to a concern of falling.

Following the allocation meeting, Anne was contacted by one of the Social Prescribers from the East PCN. The Social Prescriber visited Anne at her home. At the first visit, Anne spoke about the sad loss of her husband a year ago, and how this had affected her confidence and left her feeling very isolated. Anne explained that she used to enjoy knitting and crafts but due to Glaucoma is finding this more challenging. Anne also talked about several falls that had happened in the house.

Through a strength base conversation, Anne identified that she would like to start a gentle exercise class and to find out more about the Fall Prevention services. It was agreed that the Social Prescriber would send a referral to the Falls Prevention Service, gather some information about the local knitting and craft groups and ladies’ groups.

From the activities the Social Prescriber identified, Anne decided to visit the local games group with the Social Prescriber, and she also agreed for the local woman’s group to contact her direct because the group offered support and transport to people who would like to access the group.

When the Social Prescriber and Anne were leaving to go to the Game Group, the Social Prescriber noticed that Anne struggled with access at the front of her house. This was raised with the Falls Prevention Service so they could do an assessment when they visited.

Anne is now attending 2 activities which has improved her confidence and reduced her social isolation. The Falls Prevention Team have done an assessment and Anne is on the waiting list for the Falls Prevention classes.

Social Action Fund

The Social Action Fund made £850,000 available to fund five projects over a three-year period. Applications set out how their project would contribute towards:

- Tackle social isolation in Oldham
- Be transformational/innovative either in the delivery approach or the system change made within the VCFSE, with the public or enterprise.
- Improve the mental health, physical health and wellbeing of people in Oldham
- Support a reduction in the pressure on health services
- Take a strength-based approach to working with people

Qualitative Analysis

Qualitative research will be presented by stakeholder cohort to enable direct comparison of experiences and perceptions between different groups.

- **Strategic** – feedback from leaders and individuals in strategic roles across the system
- **Delivery** – feedback from individuals in operational positions and delivery partners
- **Partner services** – such as social care, health and public health who may not be directly involved in service delivery but are a beneficiary of the outcomes of the Thriving Communities programme
- **Service Users** – groups and individuals who have accessed services through Thriving Communities

Strategic

Figure 4.10: Social Action Fund Strategic Stakeholders Qualitative Data

Delivery

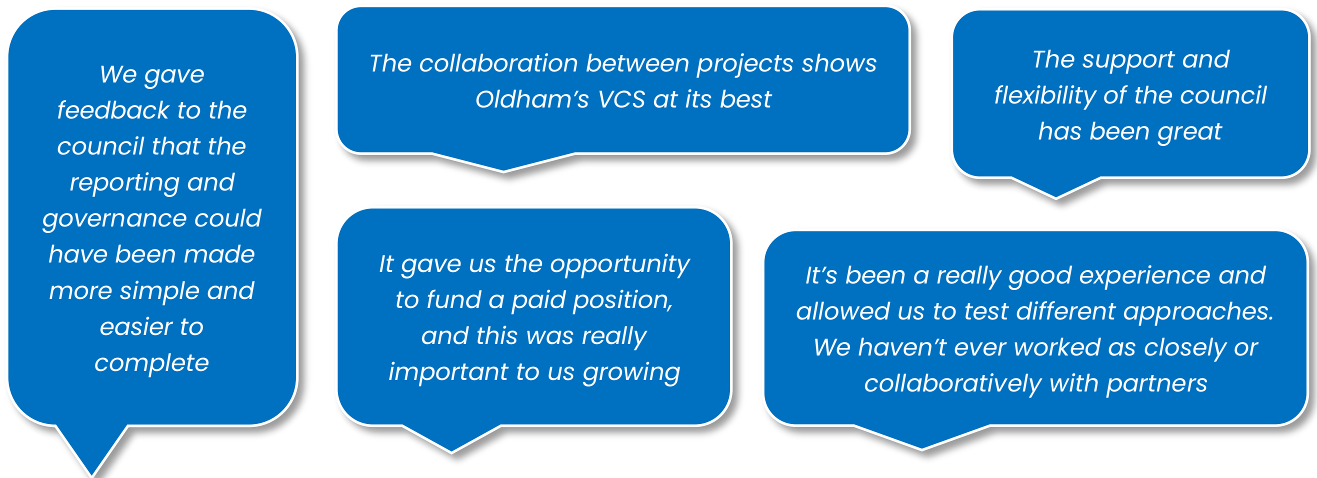


Figure 4.11: Social Action Fund Delivery Partners Stakeholders Qualitative Data

Partner services

Figure 4.12: Social Action Fund Partner Services Stakeholders Qualitative Data

Service Users

Figure 4.13: Social Action Fund Service User Stakeholder Qualitative Data

Strategic stakeholder's experiences and perceptions of the Social Action Fund as a workstream of the programme were positive, identifying the role investment in specific and targeted projects had had on reaching previously unengaged communities. There were positive comments on the role the projects had played to improve community cohesion, demonstrated by co-delivery of events and initiatives between groups. However, there was a perception that the Social Action Fund was not fully integrated as part of the system-wide approach.

The majority of qualitative feedback was provided by delivery partners and service users. This painted a picture where the projects had clearly had a huge impact on the people they were working with, as well as improving capacity and capability of the groups delivering the projects. The projects successfully built communities of interest and communities of identity. One service user commented *'…I felt safe attending the group because of the community and friends I had there'.* This demonstrates building networks and cohesion in communities for people who were previously unlikely to engage in projects of this kind.

Throughout the pandemic, projects were flexible and adapted to remote delivery. Many service users saw this as a major positive, however, this was also seen as a challenge due to a lack of computer literacy. Despite this challenge, service users commented that they hope that online sessions continue. There must, therefore, be consideration for investment in computer literacy skills for those who attend the sessions to ensure communities remain engage benefit from the projects.

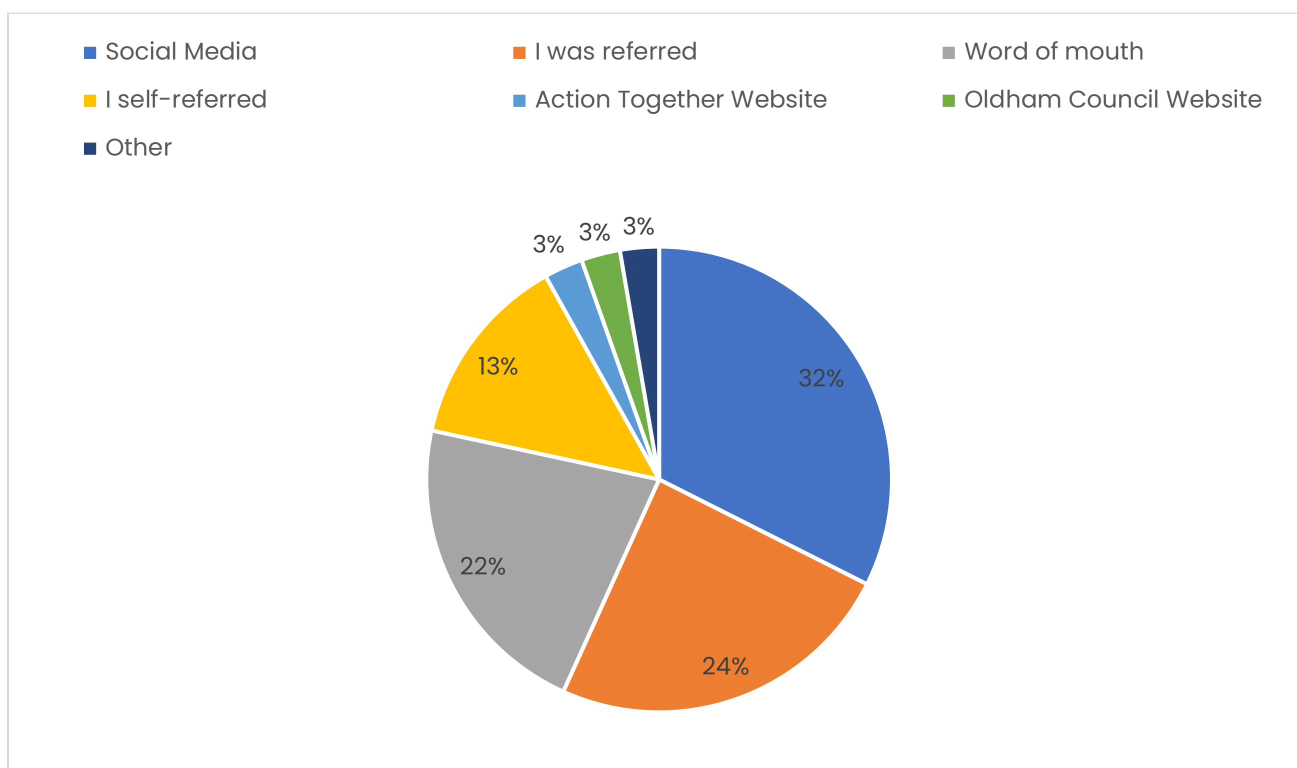
A key challenge raised by the delivery partners was the governance expectations – with one stakeholder suggesting the process needs to be made *'more simple and easier to complete'*. This feedback needs to be balanced with the recognition that the governance was in place to monitor the spending of £850,000 of public money and therefore auditing and progress tracking was a necessary evil to ensure public value was being delivered.

Quantitative Analysis

For the Social Action Fund, quantitative data was gathered from two sources. Firstly, a survey was completed during the summer of 2021 to gather feedback from service users on their experience as part of one of the projects. Secondly, data collected by projects throughout delivery has been used.

Method of First Interaction

Survey results showed that almost a third of participants who responded found information about the group via social media. Combining this with the joint 6% who found information on the groups via the Action Together or Oldham Council website, this shows that almost 40% were discovering and accessing services online. This, again, highlights the importance of VCFSE sector presence online and capability to promote and deliver service remotely.

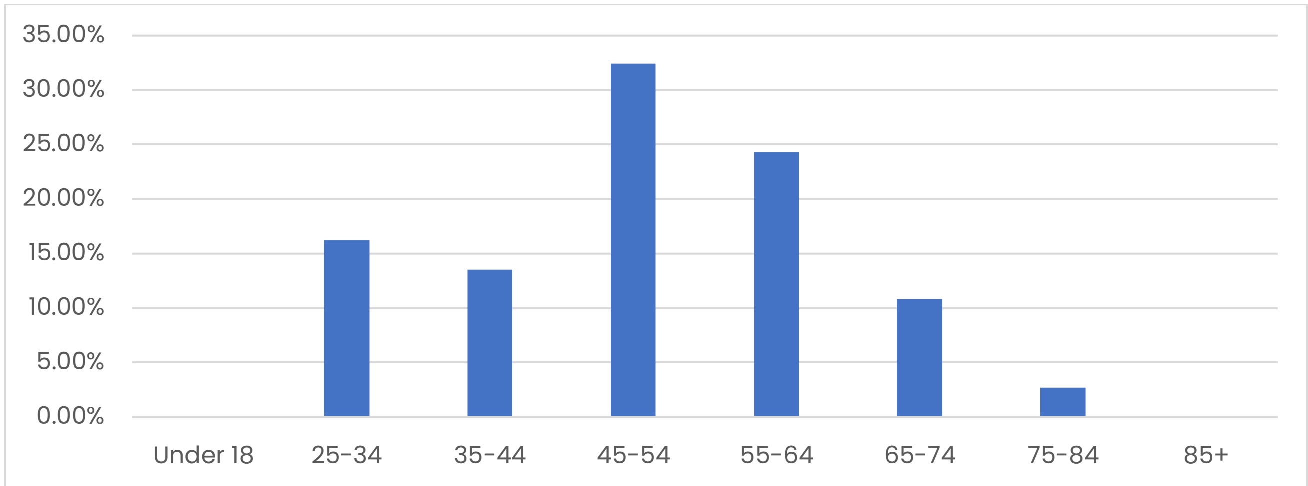


Graph 4.8: How did you find out about the Social Action Fund project?

Participants by Age

When survey participants' age was broken into age groups, there is a similar breakdown to Social Prescribing with older working aged adults (45-64) making up almost 60% of Social Action Fund project attendees. Interestingly, one major difference to Social Prescribing is the increased % attendees of those under 34. This could show the impact of a project targeted towards a given community of interest, identity or geography and therefore increasing the participation rates of younger people.

Note: the survey was not completed by under 18s, however the projects routinely worked with families and children during project delivery.



Graph 4.9: Social Action Fund Project Participants by Age Group

The survey results also showed that there was a large divide between female to male participation, with almost 80% to 20% female to male response rate. Finally, and most telling, 100% of survey participants said they would recommend the Social Action Fund project and activities they were involved with. This positive feedback is replicated in the qualitative analysis.

Further statistical analysis by project is presented in the project review section, below.

ONS4 Wellbeing Scores

To further our understanding of impact, outputs and outcomes of the Social Action Fund projects, those who engaged with the service were asked to complete a simple four-question questionnaire as part of a survey undertaken during the evaluation. This methodology is ONS4, created by the Office of National Statistics and regularly used as a method of measuring wellbeing scores.

Due to small sample size, the results allow for 95% confidence level but a 12% margin of error. This means that the results from our survey group might be up to 12 percentage points different from the results we would get from the whole population. Despite this larger margin of error and applying worst case scenario, percentage improvements across each of the question would be similar to those achieved from Social Prescribing service users.

Question	Average Score Pre-Engagement	Average Score Post-Engagement	% change
Q1 Life Satisfaction	3.5	6.7	↑ 32%
Q2 Worthwhile	3.8	6.7	↑ 29%
Q3 Happiness	3.5	6.3	↑ 28%
Q4 Anxiety	6.9	4.0	↓ 29%

Table 4.12: ONS4 Wellbeing Scores for Social Action Fund Service Users

Project Review

BAME Connect

Project Overview

The overall aim of this project is to reduce loneliness and social isolation by involving, engaging and supporting socially isolated and lonely individuals into meaningful activities and empowering them to take proactive action in improving their health and wellbeing. The project seeks to reduce health inequalities that are experienced by Bangladeshi/ Pakistani community in Oldham.

The objectives of the project are to:

- Increase social connectedness, friendships and networks to reduce loneliness and social isolation
- Help this community to understand their health better and motivate them to live healthier lifestyles
- Help this community to understand the health and social care system and when and how to access the appropriate services
- Reduce dependency (and pressures) on health and social care services, as the community adopts healthier lifestyle
- Help to reduce significant health inequalities that exist between Bangladeshi/ Pakistani residents and the wider community in Oldham
- Improve wellbeing (mental and physical) via bespoke service user focussed activities

The project has delivered a programme of activities from three hubs in Werneth, St Mary's / Alexandra and Coldhurst. The project adapted its model for delivery throughout the pandemic to keep connected to their participants.

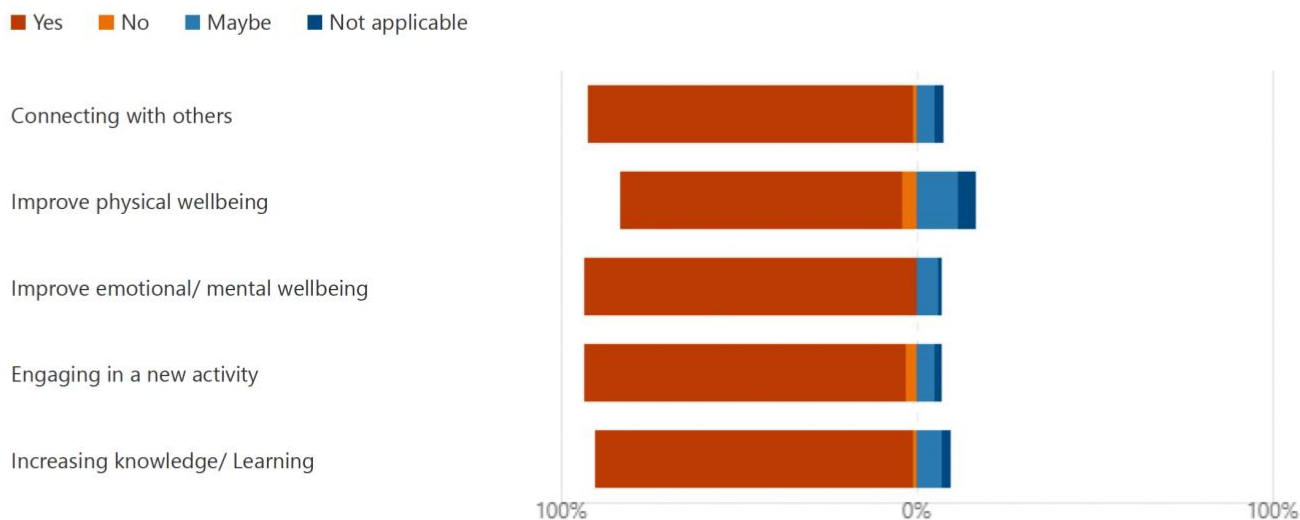
Monitoring and Reporting Statistics

Since launching, the project regularly engaged with over 150 people every quarter across the range of activities provided. This included 30+ people attending Coffee and Connect sessions and 20 young girls aged 8-15 attending Youth and Connect sessions. Some activities were delivered in collaboration with other Social Action Fund organisations, such as virtual Yoga and Connect – a six-week programme attended by 20 women delivered with Wellbeing Leisure. The project has successfully recruited and trained volunteers throughout the programme to add capacity to the delivery of activities.

As the pandemic hit and lockdown restrictions were put in place, the project and its resources were flexible and targeted services to those in crisis. Between April and May 2020, the project undertook 120 doorstep visits to check-in on families, delivered 50 medicine packs and over 250 food packs to individuals and families in crisis. The project also set up Zoom calls which were attended by over 100 families throughout the first lockdown.

Results from a surveys completed by the project throughout delivery show positive quantitative and qualitative feedback. Off 102 responses, an overwhelming majority said the project had helped

them connect with others, improve physical wellbeing, improve mental wellbeing, engage in a new activity and increase their knowledge.



Graph 4.10: BAME Connect Outcomes

In addition to this, when asked on a scale of 1-5 (1 being poor, 5 being the best) how they would rate the activity, the average score was 4.68.

Case Study and Participant Feedback

NK is a young Pakistani woman who recently lost her husband. She has two children aged 10 years old and 5 years old. During the first lockdown the referral came through NK children's primary school who had also referred to Early Help. NK lives with her children in a flat and does not have any family or friends to support. NK was referred for support with financial issues and housing. Due to the loss of her husband, she also required emotional support.

NK received weekly phone calls, support and advice regarding children's behaviour, financial issues, and also accessed sportswear from an initiative through JD Williams during lockdown. NK was referred for support with weekly food parcels. Early Help was actively involved by providing support and advice to NK and also helped with housing and benefits.

BAME Connect and Early Help worked collaboratively to ensure NK received the right support for herself and her children. NK was given support for a total of 4 months and was discharged from Early Help. BAME Connect has supported NK with financial issues and was now waiting to be rehoused.

NK received befriending calls from BAME Connect for a few weeks after the other organisations discharged her. NK was offered counselling once the children started school in September. NK was also offered access to classes at Fatima Women's Association once lockdown had finished and the centre had reopened.

NK built a good relationship with BAME Connect and stated how she felt like she had friends who she could talk to and support her.

Wellbeing Leisure

Project Overview

The project partnered with community groups to provide physical activity and health and wellbeing opportunities. The project also offered the opportunity for volunteers to learn skills and gain qualifications in health and fitness.

This project addressed social isolation and loneliness by increasing the number of social contacts an individual would have within their own community and encouraging regular engagement through participation in activities that they feel benefit from.

The benefits of exercise are well documented, including better health, reduced risk of serious diseases, lower blood pressure and increased bone health. Exercise also brings social benefits, particularly in relation to improved social and psychological health with increased feelings of wellness and confidence through social interaction.

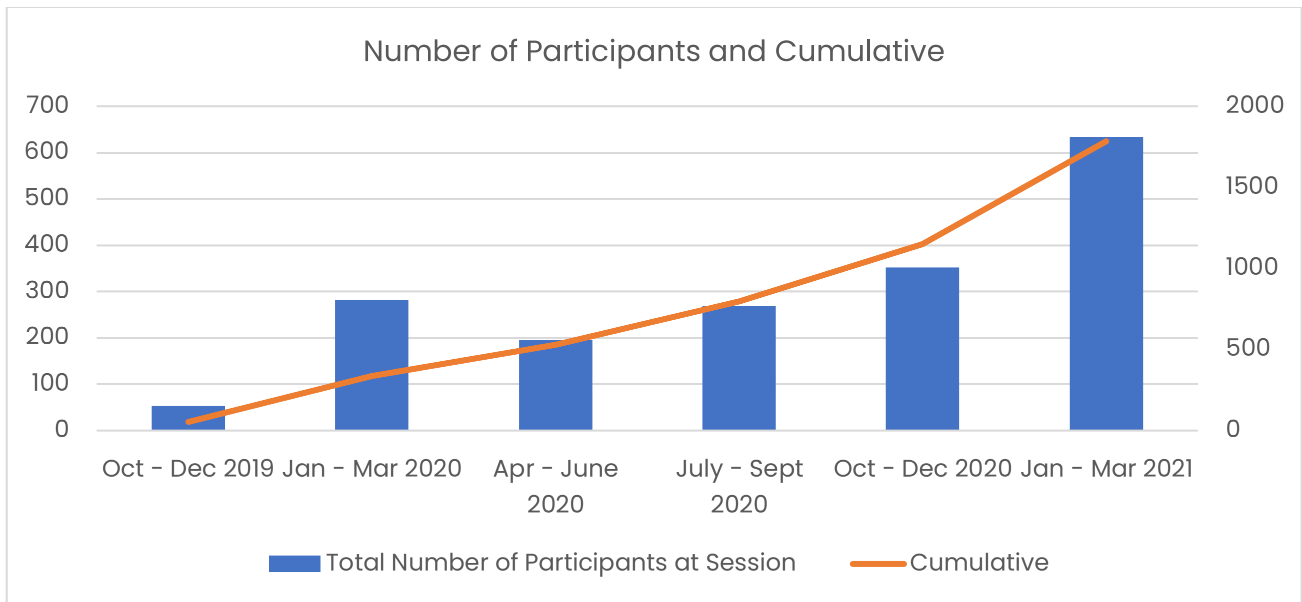
The objectives of the project were to:

- Provide improvement in health and wellbeing for all communities of Oldham which have been identified within this programme
- Provide an exercise programme which both health professionals and social care organisations can refer into
- Raise awareness of health needs amongst local communities by providing quality services and tools to promote good health and expand the opportunity for people to engage within community settings
- Work with volunteers to increase knowledge around health and wellbeing and provide local support
- Provide an opportunity of cross communication and learning from good practice amongst community groups

Monitoring and Reporting Statistics

The project and activities have been influential at promoting and engaging people in physical health and wellbeing activities. As graph 4.11 shows, below, there has been a total of 1,784 attendances (right axis) at Wellbeing Leisure activities. Attendances have grown quarter on quarter over the second year of delivery, with most quarters between 190-350 attendees (left axis). This sharp rise in early 2021 is likely to be facilitated by the lockdown, combined with group's improved online capabilities and service users' expectations and experience of attending online sessions.

Furthermore, Wellbeing Leisure have established partnerships with organisations and other VCFSE groups across the borough. In January – March 2021, this peaked at 26 different partner organisations. This brought health and wellbeing activities to harder to reach groups and targeted groups. For example, in February 2021, Wellbeing Leisure delivered baby loss bereavement and yoga sessions in partnership Beyond Bea.



Graph 4.11: Wellbeing Leisure Number of Participants

Wellbeing Leisure have also trained 38 volunteers throughout project delivery. This improves the sustainability of the activities, as well as continuing engagement in physical wellbeing activities.

Case Study and Participant Feedback

The Friday Club is an inclusive community-based group for those looking to make new friends and become more active with like-minded people. It offers a variety of different activities for locals to try including indoor curling, badminton and table tennis. The group runs specialist workouts, often welcoming guest speakers and instructors, and incorporates a sociable lunch. The group brings people together from different backgrounds, abilities, and ages, with members ranging from 23 to 93 years old.

The sessions moved to online activity classes during the pandemic and delivered via Zoom. This enabled the group to remain connected and to continue to overcome loneliness and social isolation by keeping people connected and active.

One regular attendee said the sessions during the pandemic helped them as they *'looked forward to meeting up with my friends online. It was great to see so many friendly faces. I'd never used Zoom before, but with the help of staff, all my fears were overcome.'*

Oldham Play Action Group and Wifi NW

Project Overview

Oldham Play Action Group and Wifi NW delivered all-age cookery courses, bringing children, parents, carers and older socially isolated people together to prepare and cook meals. The groups – run by Oldham Play Action Group (OPAG) and Wifi North West also encouraged people to engage in active physical play as well as organise community play street events to join neighbourhoods together.

The overall aim of the project was to bring people together to improve health and wellbeing through cooking classes, baking classes and organising community play streets to make positive connections and reduce loneliness

Monitoring and Reporting Statistics
The project regularly engaged with over 250 people each quarter. Over lockdown, OPAG partnered with BAME Connect to deliver family zoom sessions with the expectation to engage with 24 families. The activity programme was shared through word of mouth reaching 120 families.

The pandemic drastically impacted the ability to deliver events planned by the project. However, the project was flexible to deliver some sessions online and also played a vital role in maintaining contact with participants, including the delivery of activity packs to homes, delivery of food parcels and medication packs.

New partnerships have been facilitated with groups including Oldham Street Angels, BAME Connect and East Oldham Crisis Hub. The project has also strengthened partnerships with Early Help and Greenacres Community Association.

Case Study and Participant Feedback
OPAG have supported the delivery of 'Play Streets' across Oldham. A Play Street takes place when a group of residents close off the road to through traffic for a short period to create an opportunity for children to play freely and safely and in so doing bringing communities together.

Play Streets are regularly attended by 30+ residents. Play Streets in Failsworth and Hollinwood brought families together from different backgrounds and was also attended by councillors. There were similar Play Streets delivered in Chadderton and Coldhurst, with 30-50 attendees and longer half-day Play Streets with 80 residents.

There was positive feedback that the projects created a community spirit and improved community cohesion. The sessions brought together people who had lived together for many years but not spoken before.

Street Angels

Project Overview
Street Angels has grown upon the already excellent work taking place in Oldham town centre on Saturday evenings and expanding into Friday nights. Teams of volunteers and medical staff are there to support those enjoying Oldham's nightlife providing a listening ear, first aid and basic medical treatment as well as making sure people get home safely. As part of the programme, an evening drop-in and hot meals were provided for people on the streets as well as daytime support from the Street Angels centre.

The original objectives included:

- To make the Saturday night-time environment a safer and fun place to be
- To offer first aid and basic treatment without the need to visit A&E

- To build relationships with 'frequent flyers'
- To employ a development worker
- To extend the core services to include Friday as well as Saturday nights
- To consider other services which might enhance the project

Monitoring and Reporting Statistics

A series of indicators have been measured since the launch of the project. The statistics show significantly growing needs with nearly twice as many visits from guests from year 1 to year 2 and Q1 year 3 statistics showing a continued growing demand on the services.

There is also a change in the nature of support offered, with a growing demand on provisions of clothing and personal care packages. The statistics for the Wednesday drop-in sessions show an even greater demand – with a 400% increase in guests attending and almost 10 times as many guests provided with clothing.

The role of Street Angel's in the borough response to the pandemic was pivotal in protecting and supporting homeless and rough sleepers in Oldham. Whilst this was a necessary shift in service as a response to the pandemic the project delivery team are aware that this is only addressing immediate needs rather than influencing the underlying problems.

	Year 1 Total	Year 2 Total	Year 3 (Q1 only)
In-base activity (Saturday):			
Number of sessions	52	52	13
Volunteer sessions	198	305	76
Guests attending sessions	846	1509	428
Hot meals provided	840	1508	428
Guests provided with bedding	46	52	8
Guests provided with clothing	101	846	323
Guests provided with personal care package	50	448	207
Guests provided with food and provisions	47	623	209
In-base activity (Wednesday)			
Number of sessions	34	53	13
Volunteer sessions	235	353	96
Guests attending sessions	431	1564	424
Hot meals provided	369	1559	424
Guests provided with bedding	3	34	10
Guests provided with clothing	75	748	310
Guests provided with personal care package	11	408	229
Guests provided with food and provisions	37	541	163
Volunteers			
Active volunteers at start of quarter	24	30	46
New volunteers during the quarter	8	29	2
Volunteers dropped out during quarter	2	13	0
Active volunteers at end of quarter	30	46	48

Table 4.13: Street Angels Outputs

Volunteer numbers show a positive story, with the number of volunteer capacity doubling from 24 at the start of the project to 48 at the end of Q1 of year 3.

Groundwork Consortium

Project Overview

Groundwork led a new partnership of organisations to bring a variety of new activities to venues across local communities, using growing and food to increase healthy outcomes and connectedness across the borough. As well as enjoying all that is on offer, participants were supported to develop, plan and sustain their own social groups around their hobbies and interests.

The project brings together Groundwork GM, Get Up and Grow and Talk, Listen, Change (TLC).

Monitoring and Reporting Statistics

The project, due for completion in June 2021 has been extended to enable delivery of original targets. This had been impacted due to the projects being unable to deliver face-to-face events. Variation in the tables below show that some targets had been delivered despite the impact of the pandemic and there was a clear plan to deliver reprofiled targets throughout the summer and autumn of 2021.

Groundwork GM				REPROFILED DELIVERY APR - SEP 21						
Reprofiled July 2020	**Outcome Target**	**Act Jul 20-Mar 21**	**Variance**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**TOTAL**
Sessions delivered	56	21	-35	5	6	6	6	6	6	35
Number of new settings	6	4	-2		2	1	2	1		6
Number of people attending activities	336	182	-154	20	20	20	30	34	30	154
No of individuals supported	42	121	79							
New groups created	10	4	-6		2	1	2	1		6

Table 4.14: Groundwork GM Reprofiled Delivery

Get Up and Grow				REPROFILED DELIVERY APR - SEP 21						
Reprofiled July 2020	**Outcome Target**	**Act Jul 20-Mar 21**	**Variance**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**TOTAL**
Sessions delivered	20	14	-6			4	4			8
New settings	4	5	1			1				1
No of people attending activities	200	231	31			40	40			80
Number of individuals supported	48	127	79			10				10
New Groups created	4	5	1			1				

Table 4.15: Get Up and Grow Reprofiled Delivery

TLC				REPROFILED DELIVERY APR - SEP 21						
Reprofiled July 2020	**Outcome Target**	**Act Jul 20-Mar 21**	**Variance**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**TOTAL**
1:1 / Couple Counselling sessions	330	176	-154	32	32	32	32	32	32	192
Personal and Emotional Res. Training	12	0	-12	1						
******Convert 11 PERT sessions to 38 x 1-2-1 counselling***			Add 38							
			-192							

Table 4.16: TLC Reprofiled Delivery

This highlights the flexibility of the Social Action Fund governance to enable this, as well as the commitment of projects to see through to the targets that were agreed.

Case Study and Participant Feedback
Activity feedback has been positive across the project. Participants in the activities have described how attending the group gives them an opportunity to meet and talk to people, make friends and gives them somewhere to go instead of sitting at home. Participants feel like they can mix with other residents and feel welcome and safe.

Sessions delivered by GU&G have provided support for a participant who is socially isolated because of mental ill health. One participant who attends regularly has described how the nature and art activities have provided a good distraction.

Fast Grants

Fast Grants is a 3-year rolling programme of small grants of up to £500. These grants focussed on funding small scale community innovation by grass roots community groups and organisations, with the aim of being accessible and getting funding to groups quickly. The total investment totalled £180,000, with 133 grants awarded up to March 2020. From 2020/21, funds were rolled into the Action Together Covid-19 Recovery Fund. A further 68 grants have been awarded using Thriving Communities Fast Grants funds.

Funds were allocated to meet priorities of the fund:

- Supporting the community to be fit and healthy
- Developing skills of local people
- Changing the area for the better
- Encouraging community participation

Qualitative Analysis

Qualitative research will be presented by stakeholder cohort to enable direct comparison of experiences and perceptions between different groups.

- **Strategic** – feedback from leaders and individuals in strategic roles across the system
- **Delivery** – feedback from individuals in operational positions and delivery partners
- **Partner services** – such as social care, health and public health who may not be directly involved in service delivery but are a beneficiary of the outcomes of the Thriving Communities programme
- **Service Users** – groups and individuals who have accessed services through Thriving Communities

Strategic

They are great examples of pump priming initiatives, but I don't think we have helping groups become sustainable

Figure 4.14: Fast Grants Strategic Stakeholders Qualitative Data

Delivery

We have built a great relationship with the system and even take referrals from Social Prescribing

The application was manageable, but it seemed long for a small grant. The support from Action Together was priceless

Volunteers have been trained which helps us continue the sessions

Figure 4.15: Fast Grants Delivery Stakeholders Qualitative Data

Service Users

Figure 4.16: Fast Grants Service Users Stakeholders Qualitative Data

Feedback and experiences of Fast Grants initiatives show they have had a genuine role to play in community cohesion and increasing community participation with the introduction of new activities and reaching out to new audiences. Recipients of grants suggested applying for the grant was the first time they had thought about growing their groups and was the catalyst to do so. Many grants had a short-term impact on service users but given the limited contact time with service users (sometimes only one session), projects were unable to assess or track long term impacts on attendees.

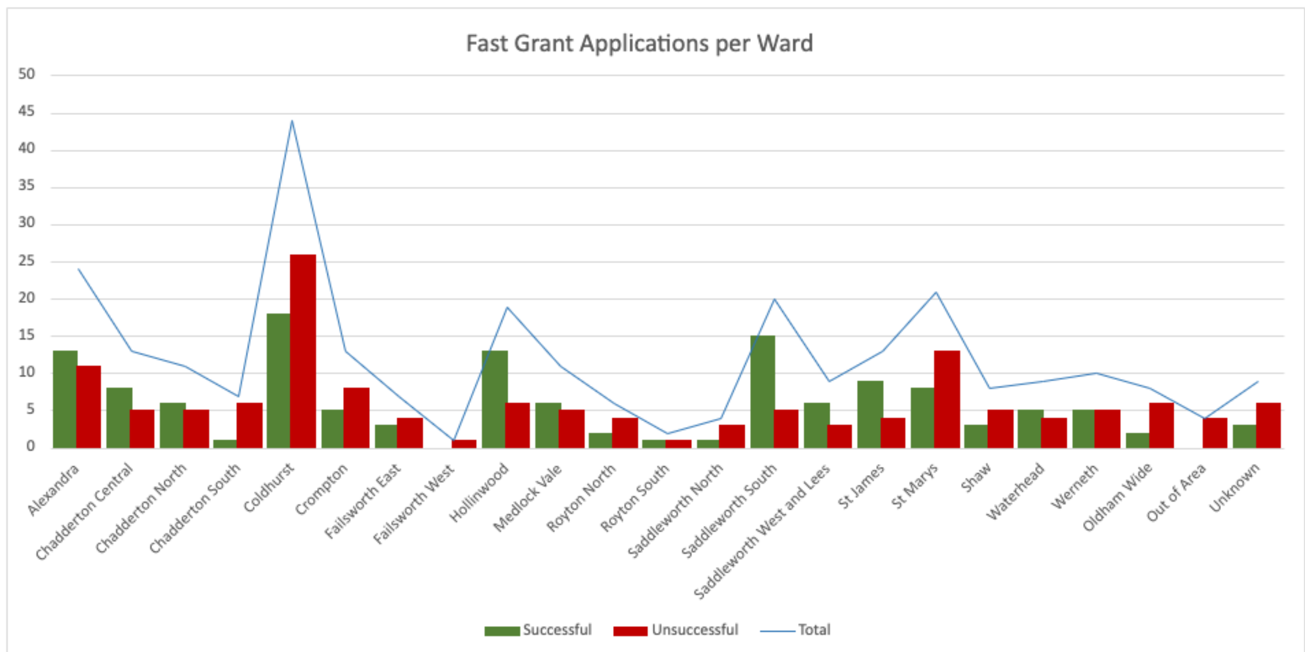
Through written feedback and interviews with recipients, there was unanimous feedback that the major challenge they faced was the short timeframe that they were able to deliver projects with the funding. Many used the funding to deliver one-off or short programmes and user feedback often asked for more sessions.

Quantitative Analysis

Fast Grant Applications by Ward

As at March 2020, before the Fast Grant funding was repurposed into the Action Together Covid19 Recovery Fund, a total of 133 grants had been awarded, totalling a spend of £60,239 out of £180,000 allocated for the workstream. A further 134 applications for Fast Grants were unsuccessful, resulting in a success rate of just under 50%.

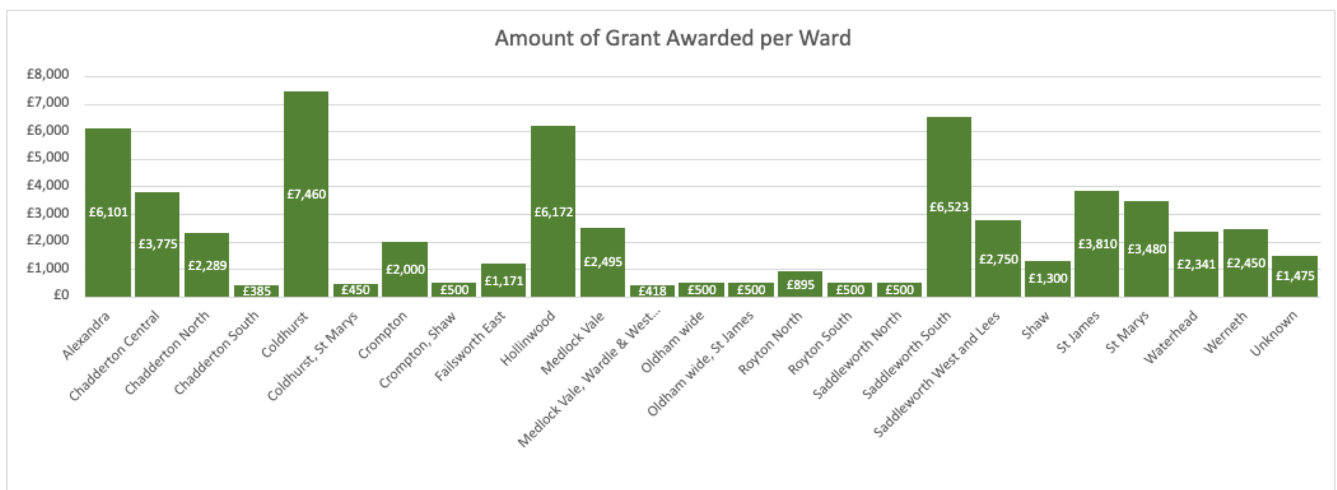
Quantitative data collected throughout Fast Grants rollout presents an insightful picture. Applications by ward show five standout wards for total applications – Alexandra, Coldhurst, Hollinwood, Saddleworth South and St Marys. Together, these wards make up approximately 47% of all applications and approximately half of all successful applications. Across the other 20 wards, there is broadly an even split of applications.



Graph 4.12: Fast Grant Applications by Ward

Fast Grants Awarded (£) by Ward

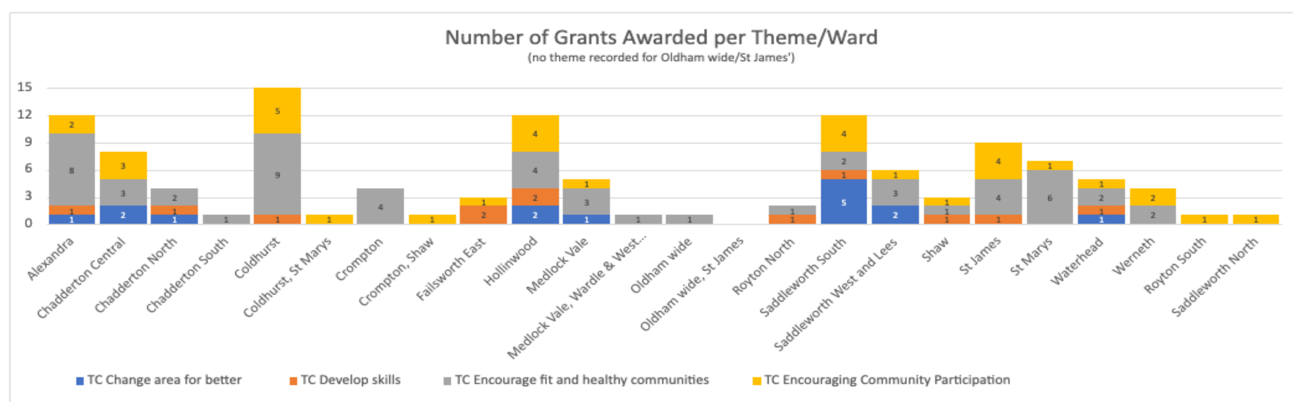
Viewing awarded grants by total value shows four wards received over £5,000 of Fast Grants; Alexandra, Coldhurst, Hollinwood and Saddleworth South. This accounts for 43.5% of total funding allocated and covers wards that are home to 21.3% of Oldham borough's population. This uneven distribution suggests targeted allocation, as is presented in further detail below.



Graph 4.13: Fast Grant Awarded (£) by Ward

Fast Grants Awarded by Priority

Finally, presenting grants awarded by the four priorities shows an uneven divide by priority. Nearly 70% of grants were awarded to projects that set out to 'encourage fit and health communities' (43%) or 'encourage community participation' (26%). The priority to 'encourage fit and healthy communities' was particularly evident in Alexandra (8/12 awarded), Crompton (4/4 awarded) and St Mary's (6/7 awarded). There was a similar number of grants awarded to change areas for the better and develop skills.



Graph 4.14: Grants Awarded by Priority and Ward

Priority	Number of Awards	Value
Change area for the better	16	£7,386
Develop skills	12	£5,162
Encourage fit and healthy communities	58	£27,446
Encourage community participation	34	£14,407
Unknown	13	£5,837
Totals	**133**	**£60,239**

Table 4.17: Number of Grants Awarded by Priority

Thriving Communities Index Analysis

For the four wards awarded over £5,000 in Fast Grants, further analysis was undertaken to determine if grants had been awarded to tackle targeted issues. This gathered data from the Thriving Communities Index and ward profiles to determine the demographic make-up of each borough and align this with the projects supported.

Ward	Average Household Income (ranking)	Children from low-income families (ranking)	NEET (ranking)	Pop living with long-term illness (Oldham avg. 16.3%)	Reported Anti-Social Behaviour (ranking)	Feel involved in local community (Oldham avg. 26%)
Alexandra	18th	2nd	4th	23.3%	1st	20%
Coldhurst	20th	3rd	16th	19.9%	2nd	22%
Hollinwood	17th	1st	1st	20.3%	3rd	14%
Saddleworth South	2nd	20th	19th	16.7%	18th	57%

Table 4.18: Top 4 wards by grants awarded – demographic statistics

This showed that across economic, health and social indicators, Alexandra, Coldhurst and Hollinwood are consistently ranked as the most deprived wards in Oldham or have indicators below the Oldham average. Saddleworth South, on the other hand ranks highly across economic and social indicators, with health indicators near to the borough average.

Whereas weighted distribution of grant funding for Alexandra, Coldhurst and Hollinwood is clear, further analysis for Saddleworth South shows an aging and disparately populated ward. This has led to growing issues around loneliness and isolation.

Case Studies: Projects Review

Supporting the community to be fit and healthy

All Start Sports Breakfast Club
The majority of Fast Grants in Alexandra targeted the priority to 'encourage fit and healthy communities'. Funded projects also tackled some of the economic indicators, such as All Starts Sports Club, which delivered a 10-week breakfast and multi-sport club aimed at encouraging children from low-income families to participate in activity. Feedback from children and parents was positive, with parents commenting that '*the children have come out of their shells and have a good bond with the coaching staff and other children'.* The project support 30 children for 10 weeks.

Peaceful Minds CIC – Dance Therapy
A second project that focussed on encouraging fit and healthy communities was dance therapy sessions delivered by Peaceful Minds CIC. The sessions worked with predominately South East Asian women and helped individuals who were socially isolated to interact and meet new people. The sessions focussed on how dance can help relieve stress and build self-confidence. The sessions were accessible for people with disabilities. Feedback included *'my first session was brilliant, very informative and great to meet new people'* and '*I thoroughly enjoyed the session, I feel refreshed'.* The project supported 29 people over 12 weeks.

Developing skills of local people

Skills 4 All – STEM after school clubs
Skills 4 All delivered two after school clubs for children in Greenacres and Clarksfield focusing on STEM (science, technology, engineering and maths) subjects. 28 children participated across the two sessions, with 95% BAME and 60% pupil premium students. In addition, 17 out of the 28 were girls, who are often underrepresented in this subject area. After having attended these taster sessions, Skills 4 All have reported increased attendance at their regular sessions and a number on the waiting list.

Simba’s Food – Healthy Cooking

Simba’s Foods were successful with their application for a Fast Grant of £480 to hold two introductory sessions for a total of 11 people at the Primrose Centre in Werneth. Simba’s Foods show people how to cook their favorite traditional meals in a healthy way without the use of oils, fats, salts, sugars, or seasonings. The sessions were oversubscribed, and people had to be turned away.

Feedback on the sessions was very positive, with participants commenting: *“I liked that it’s healthy, easy and tastes good”* and *“I liked that the session was interactive, we able to try everything out and have discussions around food.”* One group of ladies who attended have set their own WhatsApp group and regularly share recipes which their families love.

Changing the area for the better

Roundthorn Primary Academy – Chai Ladies

Roundthorn Primary Academy successfully applied for a Fast Grant of £500 in June 2019. The Chai Ladies, a group of Asian women, meet weekly at the school. The school pay for the group leader as it provides a really good way for the ladies, who can be socially isolated, to meet and have new experiences. They wanted the Fast Grant to enable them to make a tapestry which was to be displayed in the school, celebrating diversity, inclusivity, peace, and unity and for the tapestry to be a lasting legacy of the good relationship between school and community.

Using the Fast Grant enabled the women to learn embroidery and sewing skills as well has how to make a tapestry. The Mayor of Oldham and neighbourhood police officer joined the women and they taught them how to do embroidery. In the workshops the women worked on the tapestry but also talked about issues and their lives. The final tapestry made the women feel very proud of their skills and the message they created on the tapestry for the community and the children.

20 women benefitted from the Fast Grant, learning skills and improved their mental health and wellbeing by building confidence and teamworking skills. The Tapestry sends out a strong message to communities and children that we are united, we are equal, and we want to spread the message of peace, unity, and inclusion.

Encouraging community participation

Chadderton Together - Tea Dances

Chadderton Together were successful with their application for a Fast Grant of £500 to help fund future tea dances. The funding was awarded to help support an ongoing programme of tea dances in Chadderton Town hall. The events help to promote social inclusion, reduce isolation and loneliness and encourage everyone to maintain physical and mental health and wellbeing.

The average attendance at each dance was 80. Most participants were from North and Central Chadderton, but an increasing number came from outside the local area. A total of 370 benefitted from the tea dances held.

Attempts to recruit volunteers was unsuccessful, which meant that there was an over reliance on a small group of individuals who were often over stretched.

The highlights included the responses from the participants, who felt that the dances had become an important part of the social calendar of North and Central Chadderton. The programme has made a positive difference for many of the participants, who have enjoyed a social activity in a supportive environment. The programme has helped increase the range of events and activities available to those living in the local community.

Roc n Rolls – Friendship Evenings

Roc n Rolls were successful with their application for a Fast Grant of £500 for the setup of a Friendship Evening to help the socially isolated people within Holts & Lees to feel a part of the community and reduce their isolation. Friendship Evening wanted to provide the community with social evenings which would also include a meal.

Friendship Evening had 17 places available which were quickly filled and a waiting list of those that were unable to reserve a place was created. These people were given first refusal on the next evening. People attending the Friendship Evening are all residents from Holts and Lees and most were over 55.

The evenings had brilliant feedback from participants indicating a beneficial effect to reduce their loneliness and social isolation. The evenings have brought people together from different groups withing the community. Interest in the Friendship Evening also brought new volunteers to the centre.

Section 5: Answering the Evaluation Questions

At the outset of the evaluation, we asked four questions. This section takes each in turn and reflects on the analysis and discussion to determine an answer.

Q1: What is the impact for the people referred into Social Prescribing or funded activities?

Social Prescribing, Social Action Fund projects and Fast Grant initiatives have, undeniably, had a positive impact on the lives of people living in Oldham. There are headlines to show this:

- 201 'pure' deflections from social care by Social Prescribing since January 2021 – an average caseload of 25 per month
- 70% positive engagements of closed Social Prescribing referrals
- Improvements of between 8 and 32 percentage points on ONS4 data measuring life satisfaction, worthwhileness, happiness and anxiety

In addition to this, qualitative findings from surveys and case studies is also positive:

- Case studies show how Social Prescribing has improved people's confidence and '*get my life back on track'* by supporting people to overcome issues with wider determinant of health, such as housing, financial advice and employment
- Social Action Fund projects have targeted communities with innovative projects, giving people the opportunity to learn new skills and meet new people
- Fast Grants have connected people with short term initiatives in their community and reducing social isolation
- Fast Grants have also targeted under-represented groups, such as encouraging young girls into STEM learning

The programme, has, of course, had challenges to overcome and still face:

- Social Prescribing and funded activities are having to find the balance between connecting with people online as they have for the last 18 months and encouraging people to meet in groups to maintain participant's confidence
- Computer literacy issues meant some people struggled to engage with online activities
- Despite encourage engaging numbers, there are still over 200 referrals into Social Prescribing that were ended with the service user disengaged
- The impact on the wider health landscape (GP appointments, A&E visits, hospital bed days) is still not proven

Although these challenges remain, quantitative and qualitative data presented in this evaluation evidence that the programme has, on the whole, had a positive impact on people's lives.

Q2: What is the impact on the public service system?

Evidence presented in the evaluation falls short of showing a sustained or substantial impact on the public service system. As one strategic stakeholder put it *'even if there is to be a positive impact, this is likely to take a few years to filter through the system'*. Return-on-investment for the programme is positive.

Quantitative findings are mixed:

- 201 'pure' deflections from social care by Social Prescribing since January 2021 – an average caseload of 25 per month
- An overall increase in GP appointments 3-months post engagement but a reduction from the majority of people who had more than one appointment in the 3-months prior to engagement
- An overall increase in A&E visits 3-months post engagement but a reduction from everyone who had more than one visit 3-months prior to engagement
- A small reduction in the number of non-elected hospital bed days

Qualitative findings also suggest the programme has not had a fundamental impact, but instead has begun to change the narrative across the wider public service system.

- Stakeholders suggested a disjoint between social care and community work remains, although Thriving Communities had laid a cornerstone for this
- There is limited oversight of prevention services across Oldham. There is no single approach to prevention, which leads to complexity in commissioning, referrals, and access to prevention services
- Pathways between services are improving, and Thriving Communities has played an important role in that, but they often remain unclear

At an operational level, there have clearly been benefits but strategically, the impact has fallen short of its target across the system. Complex change of this level requires time. This is not only a transformational change in service delivery but a cultural one across organisations encouraging a new way of working, new way of commissioning and as one stakeholder put it, a new *'philosophy'*.

Q3: What is the impact on local VCFSE sector?

Oldham was fortunate to have a flourishing VCFSE sector before the programme. Thriving Communities has been influential at promoting and empowering the sector to demonstrate its qualities. There has been a paradigm shift over the course of the programme in the value the system places on the sector and integral role it plays in service delivery.

The evaluation has evidenced this by presenting qualitative findings that show:

- Increasing reputation of the sector from the programme
- Sector representation at decision making boards and leading parts of the borough's multi-agency pandemic response

- Greater trust placed in the sector to deliver high quality services
- Volunteer numbers have increased
- Organisations now have paid roles that were previously voluntary
- Community groups now have the capability to run sessions online, expanding their reach
- Training and workforce development has been undertaken to increase capability to work with complex referrals
- Improved capability to respond to bids and funding opportunities – many projects cited their experience of bidding for Thriving Communities funding as transferrable to bids and funding they have won since
- Innovation partnership has often been referred to as 'greater than the sum of its parts', paying tribute to the impact of the model
- Fast Grant recipients commented that the funding was the first time they had thought about growth

The impact of Thriving Communities (and, crucially, the role the sector has played in its delivery) on the VCFSE sector in Oldham has been fundamental to the position of the sector. This is the standout positive from the evaluation framework. The sector has been trusted and empowered through this programme and the sector, the council and service users have benefited from it.

Q4: How effectively has the model been implemented?

Combining stakeholder perceptions of implementation with the quantitative data of project implementation gives a well-rounded view of the success of the model. There have been a number of standout positives through implementation:

- Huge public value creation in terms of stakeholder satisfaction, delivery of agreed objectives and use of public resources
- The innovation partnership as a tool for commissioning has been successful. This is evidenced from feedback from partnership members, support from commissioners and external recognition of its success with international awards
- Grant funding has been flexible and used to support the local context. Delivering Fast Grants in rounds of funding meant that the grants could be used to fund priorities at that time, as evidenced with the transfer of funding to the pandemic response fund
- Strong programme management and mobilisation meant the programme was built on solid foundations. This allowed delivery partners the autonomy to focus on services
- The thematic analysis shows that although there was confusion around 'defining Thriving Communities', the programme successfully supported community capacity and capability building, encouraged partnership working and increased the value of the VCFSE sector.

With these successes come lessons learned from challenges faced throughout the programme:

- Keeping track of original outputs and outcomes is important. The pandemic has a huge impact on the course of the programme, however, it is important to continually reflect on the original purpose and ensure this is delivered
- Avoid scope creep. Stakeholders made reference to the programme sometimes being 'all things to all people'

- Heavy governance, application process and reporting expectations put additional pressure on community groups
- Differing approaches to prevention across the borough has been a major challenge highlighted by stakeholders. The programme must act as a catalyst for the system to address this

The successes and lessons learned from Thriving Communities and its implementation give the opportunity to influence wider strategy – be that council driven or system wide. The effectiveness of programme implementation was the foundation to delivering the outputs and outcomes for those who benefited from the services, as well as partner organisations who delivered them.

Delivery of Outputs, Outcomes and Impacts

The Logic Model for the programme set out a series of outputs, outcomes and impacts for the programme to deliver. To support the response to the evaluation questions, each output and outcome has been assessed.

Delivery of Outputs

Output	Delivered	Evidence
Thriving Community Index and Nebula	Yes	System live and used by partners across Oldham
You & Your Community Survey	No	Survey has not been completed since Thriving Communities programme begun
Asset map of community organisations	Yes	Directory available on Action Together website
Health & Care professionals trained in asset-based approaches	Yes	Strength-based conversation training rolled out
Social Prescribing Network with underpinning targets	Yes	Social Prescribing Innovation Partnership supported with VCFSE projects and groups throughout the borough. Referral pathways in place with health and social care services
300+ Fast Grants delivered	No	133 Fast Grants awarded up to March 2020. Remaining funding was repurposed as part of Action Together Covid Recovery Fund, with a further 68 grants awarded
Attract external funding to deliver health & wellbeing outcomes	Partial	VCFSE groups attribute involvement in Thriving Communities to skills uplift and ability to successfully bid for other grants
Agreed strategic approach to public sector grant funding	Partial	One Oldham Fund proposal has been put forward. Decision making to take place
New approaches to commissioning with VCFSE sector developed	Yes	Social Prescribing Innovation Partnership awarded European Innovation in Politics (Community Category) 2020

Table 5.1: Delivery of Logic Model Outputs

Delivery of Outcomes

Outcome	Delivered	Evidence
Commissioners and policy makers are using intelligence and insight to support decision making and commissioning decisions	Yes	TCI live and used by partners across the Oldham system
Residents experience asset-based and person-centred conversations with health and care professionals	Yes	Service user feedback and case study examples from Social Prescribing, Social Action Fund and Fast Grants examples.
Improved social connectedness and participation	Yes	Qualitative feedback from grant funded projects show improvements in community

		cohesion and connectedness. ONS4 scores show improvements across all four questions
Increased community capacity and community development	Yes – but ongoing	Capacity and capability increased; however further development only increases the service offer to participants
Increasing health and wellbeing	Yes	ONS4 scores show improvements across all four questions
Increasing capacity in VCFSE sector to support residents through community led approaches	Yes	See evaluation Q3 above
Commissioning decisions redistribute resource earlier upstream when they yield more benefits	Partial	Evidence shows this is possible – ie, social care deflections delivered by Social Prescribing. This should be used to inform future commissioning decisions

Table 5.2: Delivery of Logic Model Outcomes

Delivery of Impacts

Impact	Delivered	Evidence
Increasing health and wellbeing	Yes	ONS4 scores show improvements across all four questions
Reduced social isolation	Partial	Qualitative feedback and case studies highlight the positive impact the programme has had on social isolation and loneliness, however, there has been increased referrals to Social Prescribing for this. It is likely that the pandemic has exacerbated this need
Improved resilience and ability to take control of health and wellbeing	Yes	ONS4 scores show improvements across all four questions. Case studies and qualitative feedback highlight examples of service users moving from crisis to self-supporting
Increasing capacity and sustainability within VCFSE sector	Yes	See evaluation Q3 above
Reduced demand on health and care services	Partial	There is mixed quantitative data showing 'pure' social care deflections but some statistics suggesting an increase in GP appointments from service users

Table 5.3: Delivery of Logic Model Impacts

Section 6: Conclusions and Recommendations

This mixed methods evaluation has presented quantitative and qualitative analysis to evidence the benefits and challenges of the three workstreams of the Thriving Communities programme. In doing so, we are able to reach a series of conclusions and recommendations for the future of the service as the programme moves towards its end date of March 2022.

Conclusions

1. The value of the VCFSE has been enhanced and so has public value

There has been a paradigm shift system-wide in the recognition, importance and value public services place on the VCFSE sector. Trust in the sector has increased, recognising the capability to deliver services.

Research undertaken in 2018-2019 showed there was a perception that community-led services did not deliver the best public value outcomes. This evaluation shows this has wholeheartedly changed. Likely facilitated by the role of the VCFSE in the pandemic response, stakeholders system wide and at all levels have demonstrated their value in the sector. From their role in strategic decision-making boards to delivery of frontline services, the VCFSE sector is an integral part of Oldham's system.

2. Social Prescribing is working in Oldham

There is national and international evidence that Social Prescribing can bring benefits to individuals and communities. Thriving Communities has given the local context needed in Oldham. From increasing social care deflections, to improved well-being scores, there is quantitative data showing the positive impact it is having. In addition, stakeholder's qualitative feedback and experiences show the impact on service users, partnership working and the VCFSE sector.

3. There is plenty of work still to do on integration

Partnerships at an operational and service delivery level have been influential in this programme. They are the catalyst for the benefits delivered to service users. Examples of projects working together, flexibility and repurposing of grant funding to adapt to the changing needs during the pandemic and external recognition and awards for the innovation partnership are all evidence of this. But there is more to be done at a strategic and system-wide level to entrench these changes. Stakeholders often mentioned the unclear nature of prevention services across the borough. This is due to the complex picture of commissioned prevention services, leading to a disjointed system. Although Thriving Communities aimed to align this, the complexity led to many suggesting was not always easy to define 'Thriving Communities'.

4. The lessons from this programme must influence wider strategy

Whether that be co-producing a system-wide approach to prevention services, introducing the successes of the commissioning model into new commissioning projects, or improving the ways in which the system engages with its service users, there is potential for Oldham to go further. The Thriving Communities Index can inform place-based commissioning to ensure services are targeted and meet specific needs.

5. Data sharing remains front and centre

Different organisations have different information about the same individual. Without data sharing, no service can provide fully person-centred support and care. Each organisation holds a piece to the puzzle of an individual's support needs. Data sharing agreements are often seen as a wicked issue, but progress is being made in Oldham. This needs to continue to benefit every organisation, and the person at the centre.

6. The role of digital delivery is not to be under-estimated in prevention services

Perhaps by accident, Social Prescribing and grant funded projects found alternatives to face-to-face sessions or group activities, forced mainly by the coronavirus pandemic and lockdown restrictions. While this wasn't the first-choice delivery method, service users responded positively and have shown a willingness for this to continue. Online delivery enabled groups to increase capacity to reach more people. However, it also raised a challenge of computer literacy with some service users unable to engage. Feedback from surveys also showed that the most common way of finding out about the group was via social media.

7. Community capacity and capability is improving

The programme has laid the foundations for growing the VCFSE sector in Oldham. Community leaders' experiences and perceptions of the programme identify areas where their capability has improved. There are the skills, resource, and desire in communities to deliver projects the support people locally. Case studies showing service users journey from crisis to self-supporting are tribute to this.

8. Is it sustainable?

Many projects have identified involvement in Thriving Communities as the facilitator for growth of their organisations and led them to bid and win funding from other regional and national schemes. This inward investment helps the whole Oldham system. There, will, of course, be ongoing need to pump-prime projects. The strong network of community projects plays a critical role as the 'social prescriptions' and prevention services.

Recommendations

Based on the findings of the evaluation and above conclusions, a series of recommendations have been put forward.

Recommendations for Oldham System

1. Create a cross-system working group to co-design and co-produce prevention model for the borough
2. Consider a single grant funding pot to pool resources for community-led initiatives and community capacity building. This will ease funding applications for organisations and create a sustained funding stream
3. Continue to progress data sharing arrangements to enable health, care and support organisations to better provide targeted services

Recommendations for Oldham Council

4. Consider funding options and models for the future of Social Prescribing and VCFSE grants from March 2022
5. Design a refreshed set of objectives, outcomes and measures for Social Prescribing that align to the funding model chosen and monitor through contract management as service becomes business-as-usual. The objectives should also be refreshed for the borough's context post-pandemic given the impact this had on the programme
6. Undertake a Thriving Communities Index data refresh to support evidence based and targeted commissioning and decision making

Recommendations for Oldham VCFSE

7. Invest in online engagement and computer literacy of your service users. Feedback from surveys has shown this is an area service users wish to maintain but not all have the capability to access
8. Continue to undertake mid-project evaluation collecting quantitative wellbeing statistics of service users to evidence improvements

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