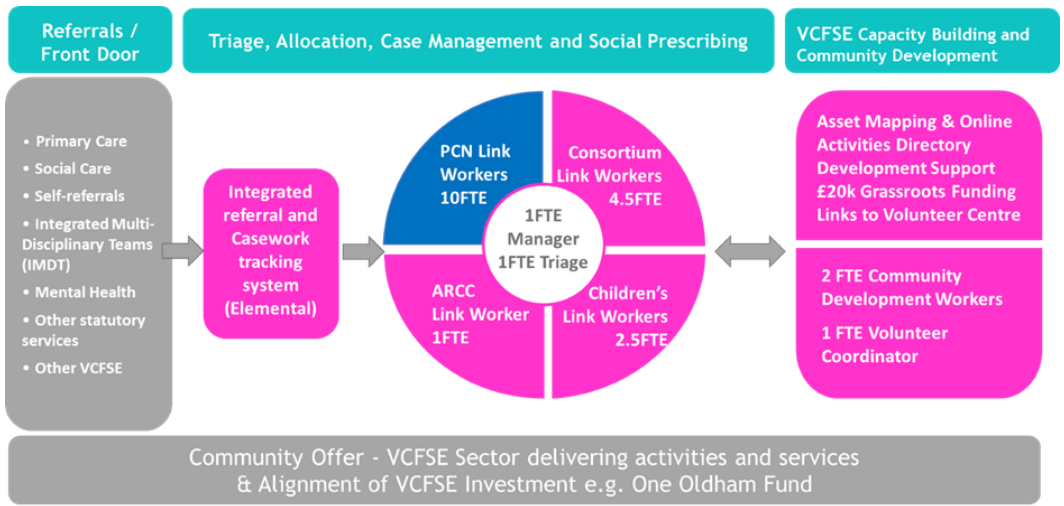
Oldham Social Prescribing

Emotional Wellbeing and Mental Health Support

About Oldham Social Prescribing

Oldham Social Prescribing Service is delivered by a consortium of Oldham Charities including; Age UK Oldham, Positive Steps and Tameside, Oldham and Glossop Mind, led by Action Together. Since 2019 the service has been co-designed by these Charities with stakeholders from across Oldham's Health and Care System.
The model brings together the three essential elements for successful People and Community Centred Approaches to care:

- Strength based, personalised care delivered via Social Prescribing Link Workers
- Asset Based Community Development and Capacity Building in the VCFSE Sector
- Grant Investment in the VCFSE to enable the delivery of community-led activities and support



Oldham Social Prescribing Innovation Partnership Impact Report

Year to Date 2023-24

Year to Date Headlines

Year to date headlines include:

- Embedding a Social Prescribing Link Worker full-time with ASC ARCC team and the difference it's making (p11)
- Social Prescribing and integrated working (p11)
- The outcomes of engaging with those who have worked alongside Social Prescribing to understand how it has benefitted them (p17)
- Working with the Family Hubs development team to integrate the CYPF Link Workers to the Family hubs approach (p8)
- The impact on improving Oldham residents health and wellbeing through wellbeing scores data (p8/9) and case studies (p13/14/15/16)

Year to Date in Numbers

- **2097** Referrals (Apr-Nov)
  - **52%** for loneliness and isolation
  - **48%** for mental health
  - **33%** for physical health / long term condition
  - **26%** for welfare and money management
- **635** Active Cases (avg each month Apr-Nov)
- **20,844** Contacts with clients or other professionals on behalf of clients
- **1,178** Social Prescriptions
- **75.4%** Increase in Wellbeing Outcomes (ONS4),
- **77%** increase in Wellbeing Outcomes (SWEMWEBS)

Year to Date Data

Fig 1 Social Prescribing Unique Referrals

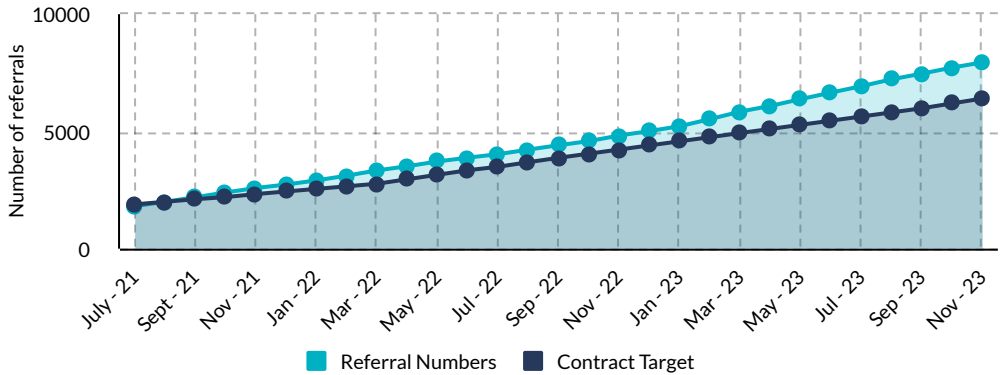


Fig 2 Social Prescribing Unique Referrals Comparison by Year

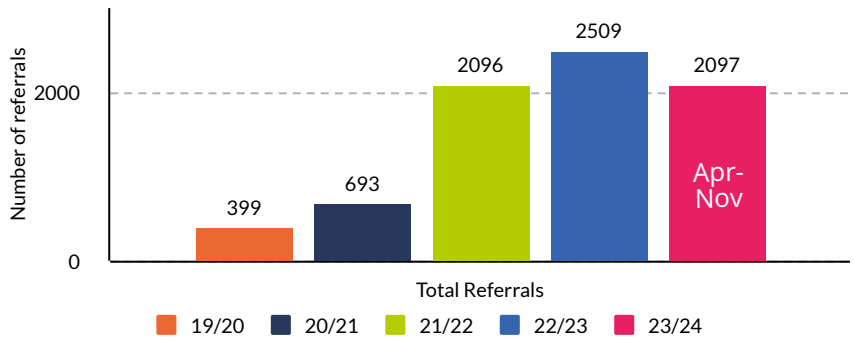
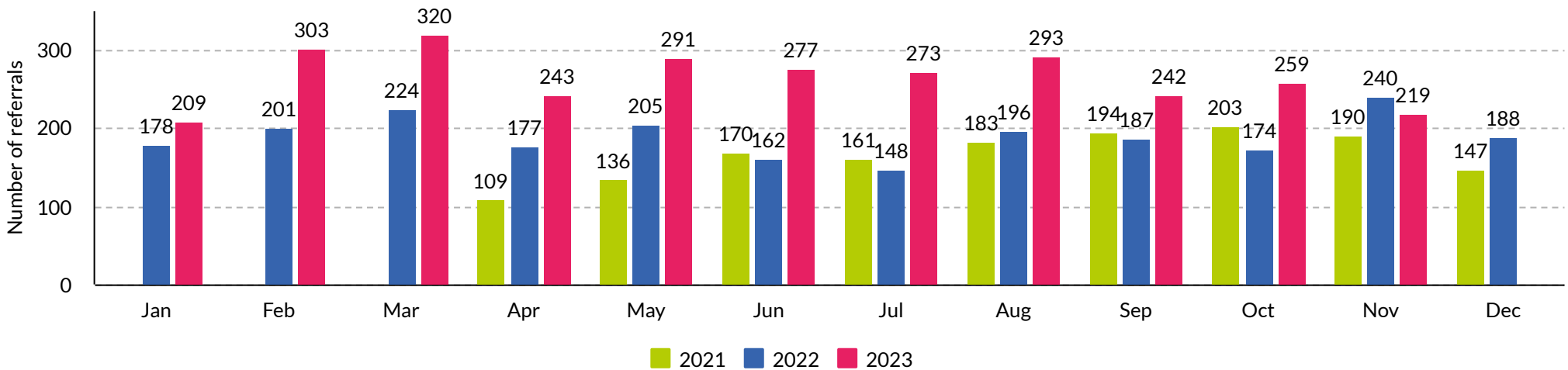


Fig 3 Social Prescribing Referrals Comparison by Month



Year to Date Data

Fig 4 % Referrals by PCN Area Q3

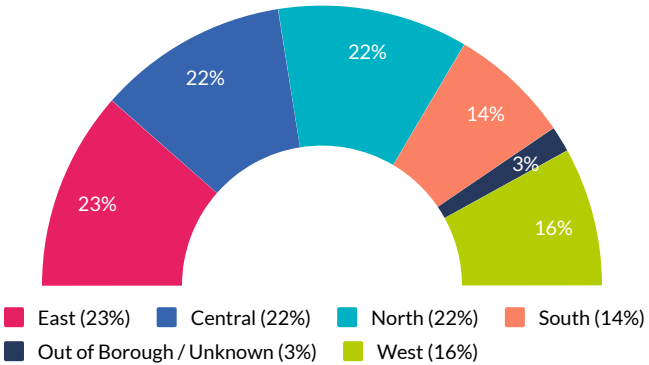


Fig 5 Referral Source Q3

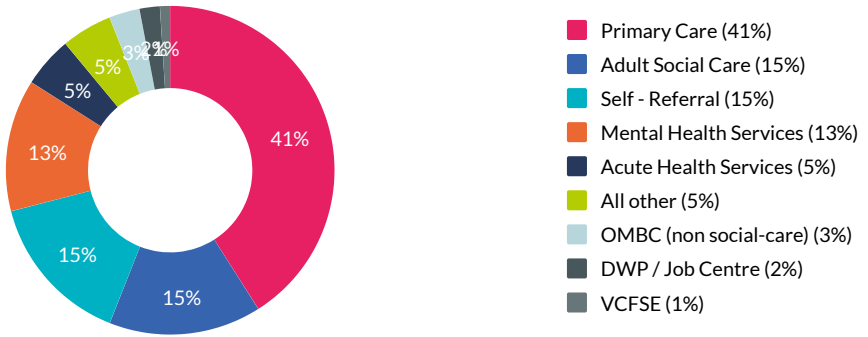


Fig 6 % Referrals by PCN Area Total Cohort

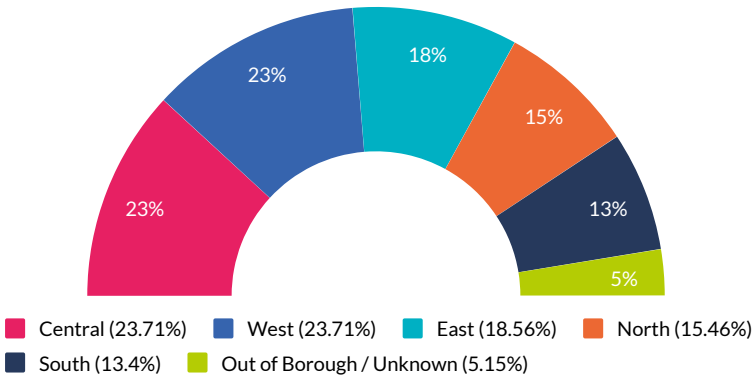
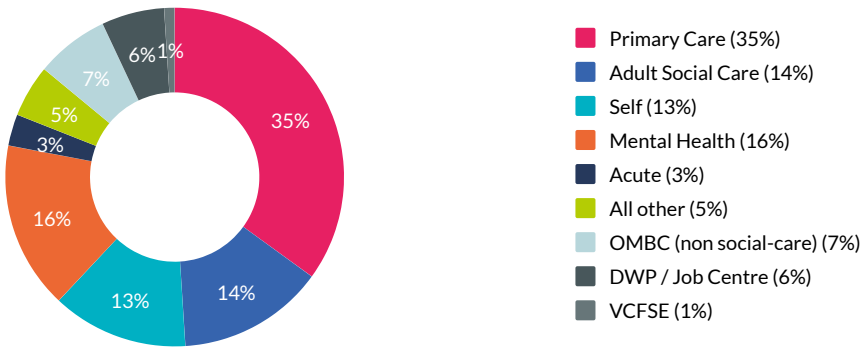


Fig 7 Referral Source Total Cohort



Year to Date Data

Fig 8 Primary Reason for Referral Q3

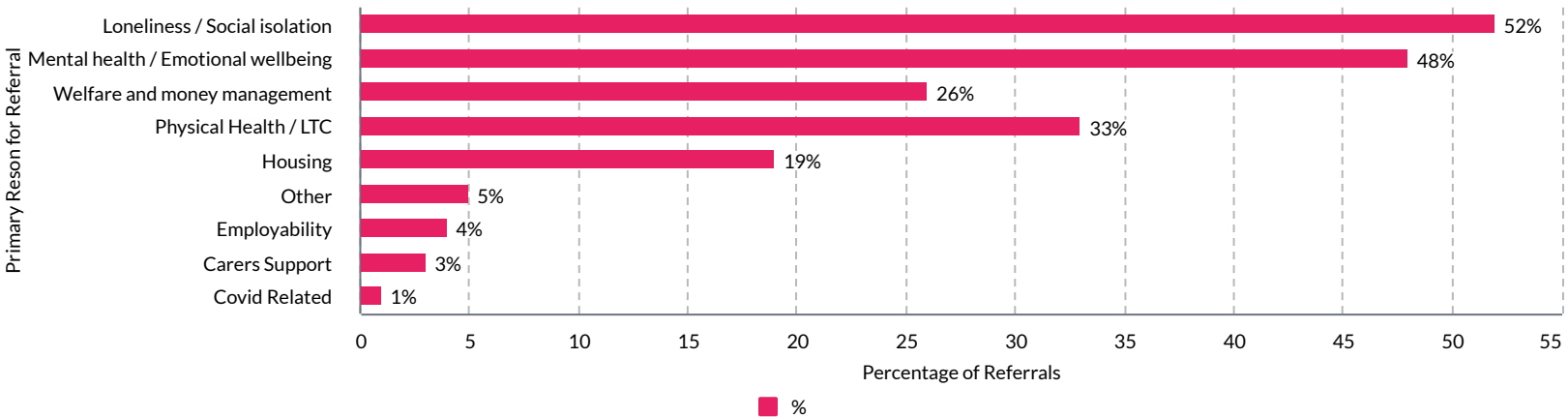


Figure 8 shows that there is an increased trend for people being referred for loneliness and social isolation

Fig 9 Primary Reason for Referral 2021-Present

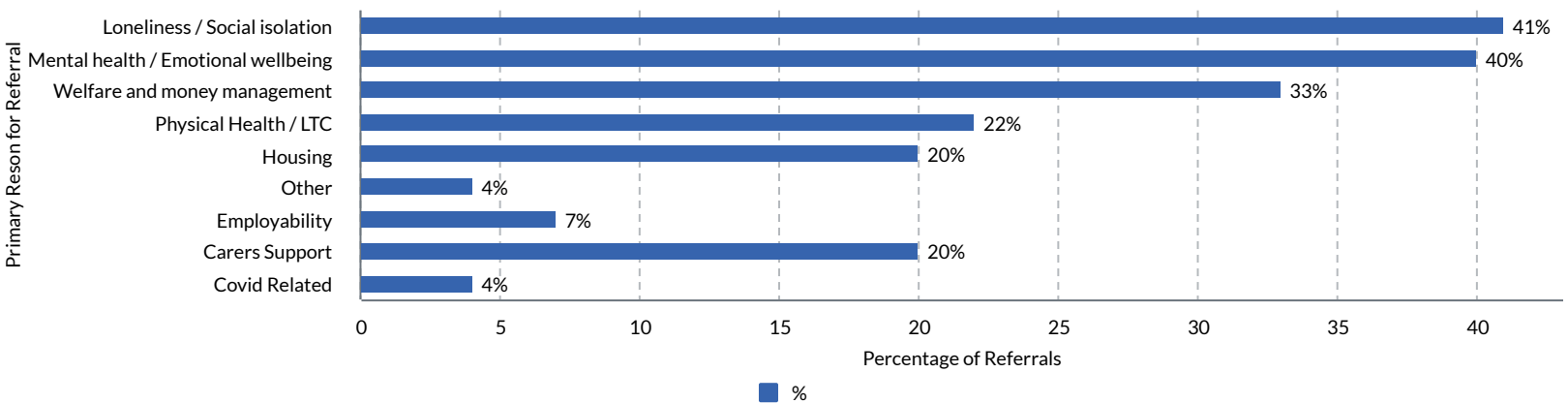


Figure 9 Since moving to Elemental we are unable to report soley on the primary reason for referral, but now we can report on multiple reasons for referral per case. This means that the percentages will not add up to 100% as 1 referral case may have 2 or 3 reasons for referral. Eg, 43% of referrals had mental health as a reason for referral.

Year to Date Data

Fig 10 Number of Active Cases (635 average per month 23-24)

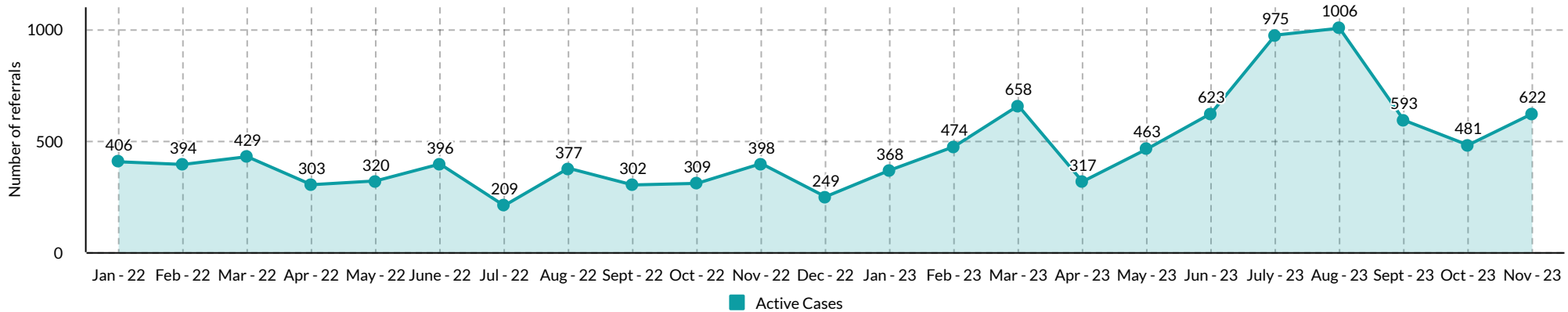
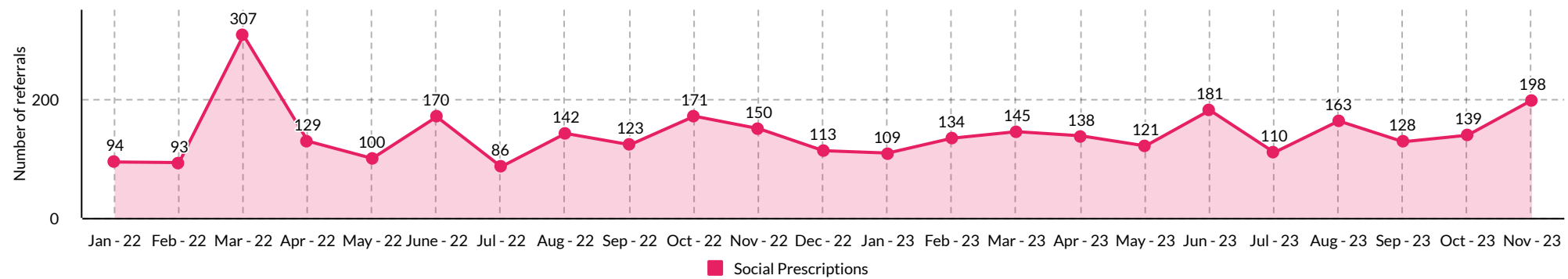


Fig 10 shows the numbers of people who are actively receiving support each month from social prescribing. In this quarter there was an average of 858 people per month actively receiving support.

Fig 11 Number of Social Prescriptions (1,178 total 23-24)



Year to Date Data

Fig 12 Number of Contacts (20,844 23-24)

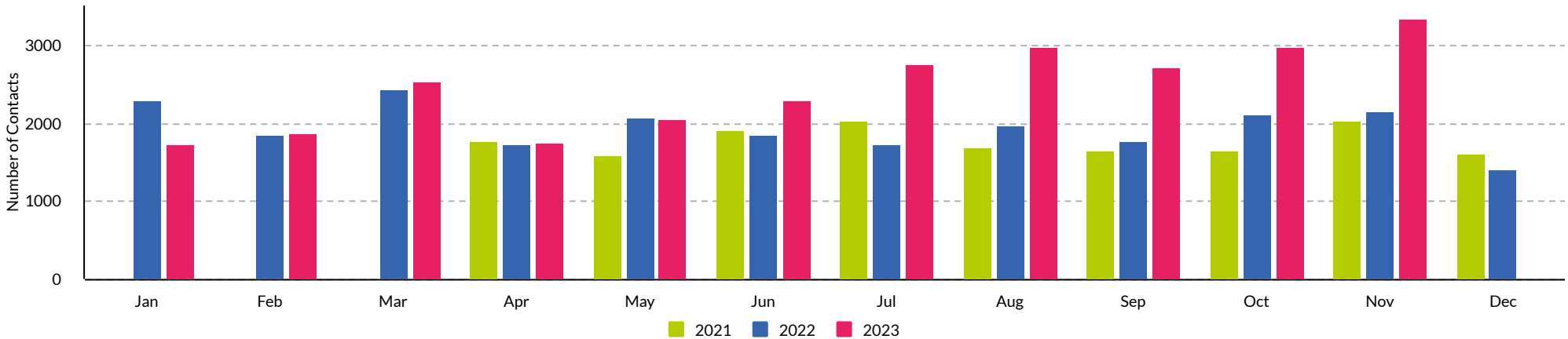
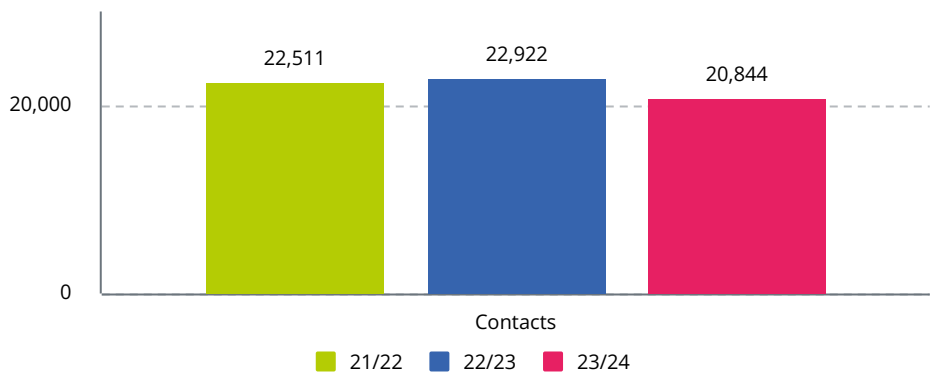


Fig 12 shows the numbers of contacts Link Workers had with the people they are working alongside and the number of contacts they had with other professionals and groups and organisations providing activities and support on their behalf.

Place Holder for Active Case Demographic Data

We collect demographic data and are waiting on the completion of a development from Elemental so that we can report on this data. As soon as this is available it will appear here!

Annual Contacts by Year



Year to Date - CYP

Fig 13 Children and Young People Social Prescribing Referrals

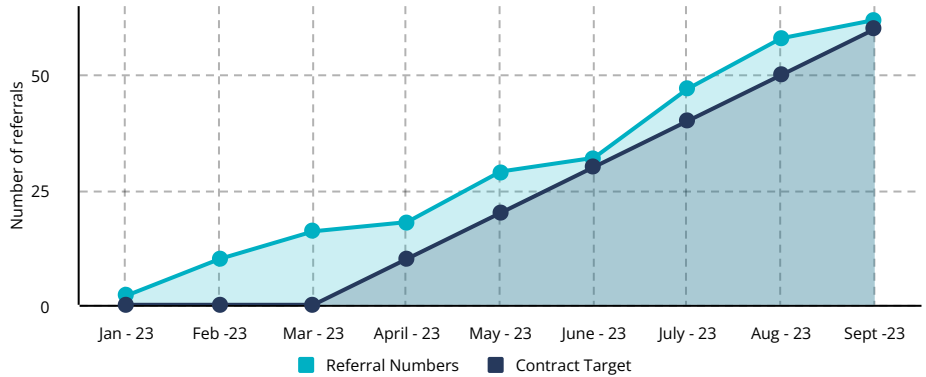


Fig 14 Referral Source Total Cohort

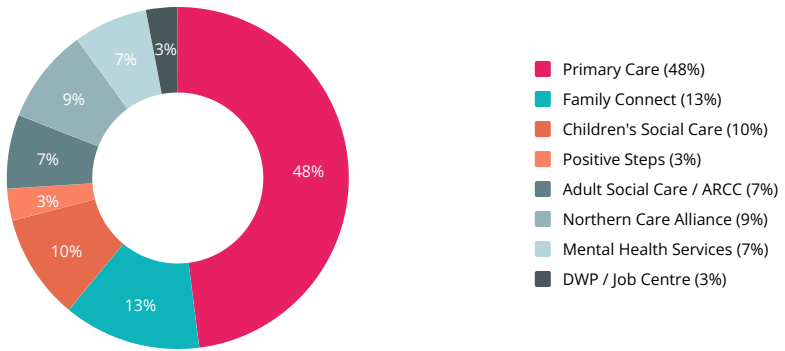


Fig 15 Children and Young People Social Prescribing Referrals Comparison by Month

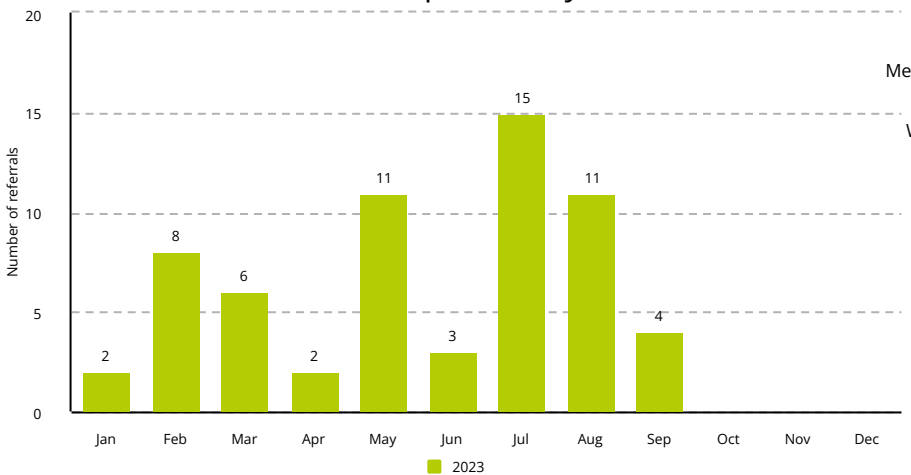
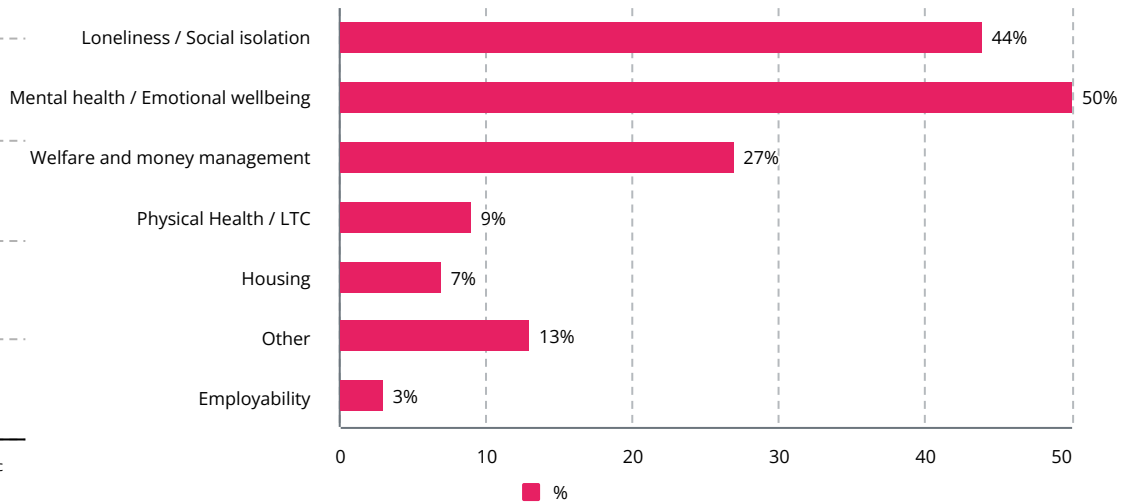


Fig 16 Reasons for Referral Total Cohort

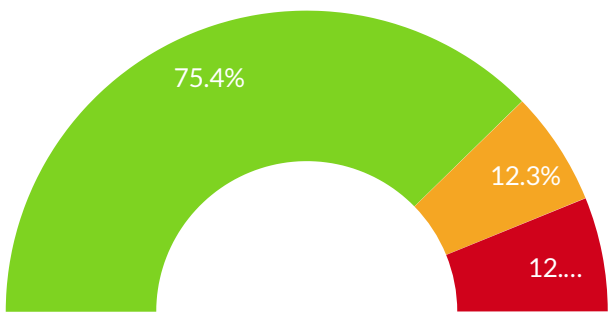


Impact - Wellbeing Scores ONS4

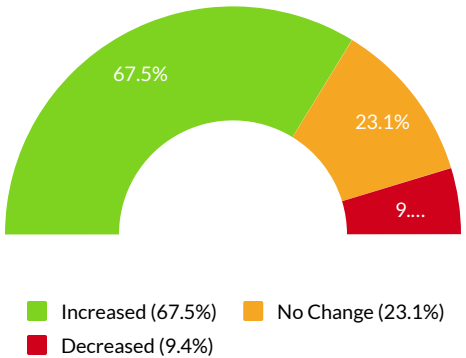
Personal well-being (PWB) is part of the wider Measuring National Well-being (MNW) Programme at the Office for National Statistics (ONS), which aims to provide accepted and trusted measures of the nation's well-being.

Personal well-being uses four measures (often referred to as the ONS4), which capture three types of well-being: evaluative, eudemonic and affective experience. Link workers use ONS 4 alongside SWEMWEBS at their initial contact, at 3 months and then at 6 months or the last contact.

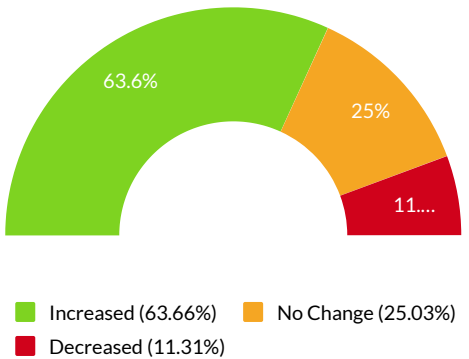
Overall Wellbeing ONS4



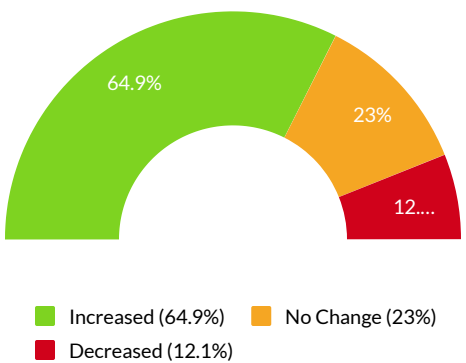
Satisfaction



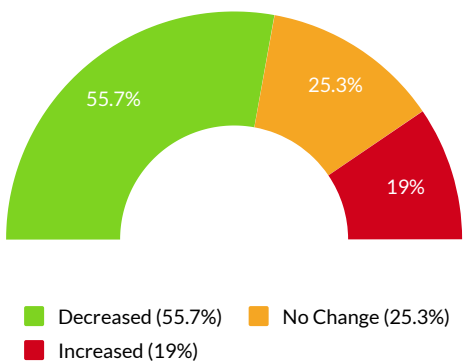
Worthwhile



Happiness (ONS4)



Anxiety

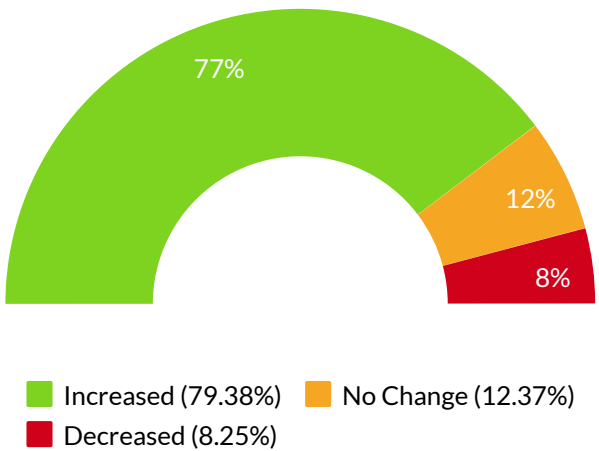


Impact - Wellbeing Scores SWEMWEBS

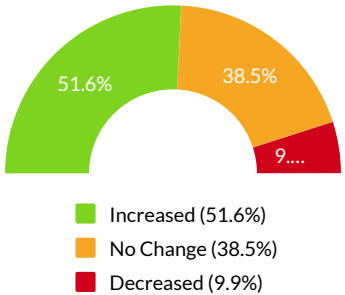
The Warwick-Edinburgh Mental Wellbeing Scales were developed to enable the measuring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. The 7-item scale SWEMWBS have 5 response categories, summed to provide a single score.

Link Workers use the shortened version (SWEMWEBS) which is a 7 item scale. We use the scale at the first appointment to get a baseline, then at 3 months as a review, and then at 6 months or at the end of the Link Worker relationship.

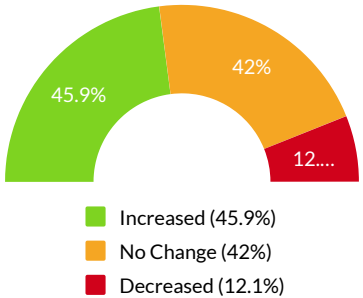
Overall Wellbeing SWEMWEBS



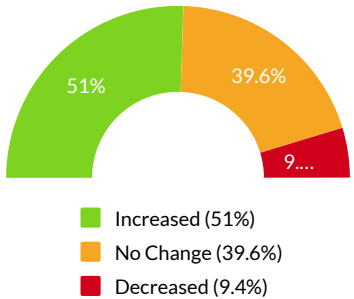
Feeling Optimistic



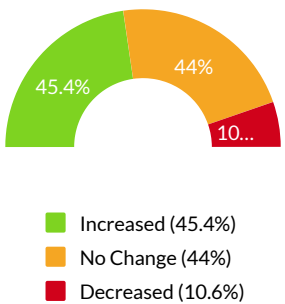
Feeling close to people



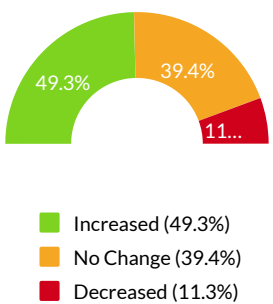
Dealing well with problems



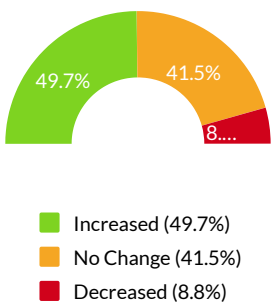
Make up own mind



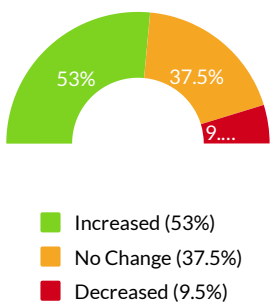
Thinking clearly



Feeling Useful



Feeling Relaxed



Social Prescribing Activity Highlights

Integrated Working

Quarter 1

Loneliness and isolation continues to be the main reason for referral in this quarter, followed closely by support needed for housing and anxiety and low mood. We've noted a slight increase this quarter in referrals for people in the age group 35-45 years. In addition to the case work, we have continued to be active partners in mulit-disciplinary team work this quarter including:

- Oldham Collaborative – Living Well
- Adult Complex and High-Risk Panel
- Making Every Adult Matter Hub
- Cost-of-living Response - Residents Requiring Repeat Support - Clean Room

In Q1 we have based a Link Worker full-time in the ARCC team. This is an additional post and has been recruited to internally to enable quick mobilisation and to provide continuity in the realtionship development between Social Prescribing and the ARCC team. Having a link worker based with the Adult Social Care front door, will improve the speed in response and the experience for people who contact Adult Social Care when a more appropriate response to meet their need is a step down into Social Prescribing. We envisage that it will also improve the experience for people who may need to be stepped up from Social Prescribing into Adult Social Care.

Quarter 2

In Q2 we continued to contribute to partnerships around integrated working highlighted above, and in addition this quarter have joined a collaborative looking at how Dove Stones can be better accessed by people working with Social Prescribing to improve their health and wellbeing.

Last quarter we saw the introduction of a Link Worker to the team at the ARCC (adult social work front door), this is proving to be very impactful, with the manager of the team reporting how it has supported with upskilling the ARCC team with the wider offer of community support and that it is having a positive effect on waiting lists and client experience. We have joint worked and taken direct referrals for 90 individuals.

Engagement and Outreach

Q1 We've supported two health and wellbeing enagaement events at the Honeywell centre and Failsworth Town Hall, on hand to talk to residents about what matters to them and what is available in their local community.

Q2 We've supported a health and wellbeing event at the Cotton Rooms for Adults with a Learning Disability and / or Autism

Social Prescribing Activity Highlights

Systems Change

We continue to be comitted to supporting system transformation in Oldham and across Q1 and Q2 have supported system change partnership work including:

- Suicide prevention planning work
- The multiple disadvantage and system change partnership day
- Multi-Agency Early Help Panel Planning Session
- Oldham Collaborative – Living Well
- What Drives Demand in Oldham Workshops

Workforce Development

Quarter 1

The team have continued to develop their skills and knowledge and have completed:

- Connect 5 Mental Health Training
- Practitioners training for encountering people with problematic drinking

We have launched The Active Travel and Social Prescribing Project (funded by TfGM) in Q1. The project will build capability and capacity within our Social Prescribing Network around active travel and physical activity, will strengthen the connections between this network and the active travel infrastructure, and will reduce inequalities that act as a barrier to active travel within communities.

The project will focus on the communities within Central Primary Care Network and will enable us to further develop our volunteer/peer support model to support delivery. These roles have been successfully recruited to the coordinator started in June and the development worker will be with the team from July, this project will build on capacity in the team alongside the opportunities we are able to offer the individuals accessing Social Prescribing.

The Children, Young People and families link workers, employed by Positive Steps, are now fully established within the team and are actively supporting children, young people and their families, this work is developing alongside the Family Hub development.

Quarter 2

In Q2 we have hosted a student placement for the NHS graduate management training scheme, the student has been delivering a project to capture the voices of the individuals that have been accessing the service. The results being a co-produce piece of work that celebrates and raises awareness of Social Prescribing, while also using the opportunity through lived experience to capture successes and learning for the future. We have shared more details on the outcome of this work in the feedback section of this report.

We have have recruited 3 Link Workers this quarter to backfill for vacant posts. Using our inclusive recruitment processes we have successfully appointed a person who has lived experience of the refugee and assylum seeker system, whose skills and experience are an asset to the team.

Case Study

Hannah

Hannah was referred to Social prescribing for support with her mental health. Hannah had been the main carer for her mother, who passed away 2 years ago, Hannah lots her husband the year before her mother. Since her bereavement Hannah has really struggled. She feels disconnected socially and is struggling with her confidence. She has also got financial issues and debt problems, all of which were contributing to her anxiety and low mood. Hannah was referred to Social Prescribing by her GP at Chadderton Medical Practice.

The link worker contacted Hannah and arrange to meet with her, Hannah explained that she prefers to talk to people in person and so they arranged to meet at a local cafe. At their first meeting Hannah talked about her bereavement, about her emotional wellbeing, how isolated she feels and about her money worries.

The link worker helped Hannah with some of the immediate things at that first appointment. Hannah's money worries were so bad that she didnt have any food and hadnt eaten properly in two days. The link worker connected Hannah to the Foodbank and arranged for a food parcel to be delivered later that day, she also connected Hannah to the SIT team to help with Council Tax reduction, which later led to a £28 monthly reduction.

Hannah and her link worker arranged to meet weekly with a check in phone call in between, the link worker introduced Hannah to the Bread and Butter Thing, which meant that Hannah could get a weekly food shop at a much more affordable price, and wouldnt be reliant on the Foodbank. The link worker supported Hannah to complete a PIP application including the evidence required from her medical records to help her maximise her income. Hannah has many physical health issues that impact her quality of life. Hannah did not think she would be entitled to any help as she recieves a small amount of income from her late husband's pension.

The link worker introduced Hannah to TOG Mind's Listening Space, Hannah has found the support there incredibly helpful and is continuing to regularly attend the Listening Space. The Linkworker is currently helping Hannah to reduce her debt burden and set up affordable payment plans. The next goal on Hannah's wellebing plan is to try a local arts and crafts group and to join the local walking group.

Case Study

Robina

Robina arrived in the UK in 2015 with her husband and 3 children. Her husband had a suddenly passed away in February 2023. She lived with her mother-in-law in a private rented property. She had no other family in UK to support her. Robina was very distressed and had very low level of mental health. Her husband had been the sole earner of the family. She was finding it very difficult to cope with the everyday roles and responsibilities with her children. She was constantly worried about her finances as she was not entitled to benefits due to her immigration status.

She was referred to Social Prescribing for low level mood, bereavement, befriending and benefit advice and she is a patient at Kapur Family Practice. Robina met with her Link Worker who could talk to her in her first language and they agreed a wellbeing plan together including:

- Connecting Robina with relevant services for her mental health and wellbeing,
- The Link Worker worked closely with the Social Worker and Children's school, providing the language and emotional support for Robina and completing a referral to UKEFF for foodbank and financial assistance. A successful application was also made to Healthy Start Vouchers scheme.
- Robina's financial situation was a huge part of her worries so we completed a UC online application after obtaining confirmation of her immigration status. The Link worker supported Robina to be more involved at meetings, explaining things in her first language, she feels that language line only interprets and isnt able to explain some concepts and procedures as the link worker can. With UC in place she had more financial independence to fulfil her, and her children needs.
- Robina registered and enrolled on ESOL and IT courses and training to further develop her skills and confidence.
- We also helped her to register with Mind Matters counselling sessions at EIC Centre for bereavement support following the loss of her husband.
- Robina engaged with ARC art classes at Oldham Library and was also supported to attend BAME Connect for social groups and yoga classes.
- The Link Worker completed a referral for the digital device gifting scheme through Oldham Libraries for a laptop as the family had no digital device for children to use for homework. This was successful and had a positive impact on the whole family.

At the time of closing the work with Robina, she is attending Oldham Lifelong Learning for ESOL classes and engaging with Werneth & Freehold Community Development Project for peer support and IT classes. She feels confident to attend activities and classes on her own, she is now more outgoing and engaging with help and support.

Case Study

John

John was initially referred into social prescribing from his GP Practice for support with reducing isolation, feeling motivated and support for housing. John lives alone and has a limited support network. John expressed wanting to move house due to anti-social behaviour issues he was experiencing in his local area and with neighbours. He wanted to improve his mood and emotional wellbeing and look at ways of feeling purposeful. John also wanted to start to do some physical activity.

The link worker met with John at a community venue that was convenient for him and over the course of the next few weeks started to build a relationship, develop a wellbeing plan and work together to take the steps required to achieve John's goals. They also kept in touch via telephone in between appointments to progress actions.

John's link worker connected him to the Volunteer Centre for exploring volunteering opportunities, as way of becoming more engaged within the community, feeling more purposeful and building confidence and better mental health.

The link worker also supported John to complete a housing application ensuring that all the relevant supporting documents were submitted. The link worker was able to support with the application to make sure the forms were all filled in correctly meaning that the application wouldn't face any unnecessary delays.

The link worker connected John to Oldham Community Leisure's Exercise on Referral Programme as away to start to becoming more active, but with the additional encoragement and support that he felt he would need.

As a result, John's housing application is being processed currently. He has registered for volunteering and has applied to a number of roles. John has enrolled on the Exercise on Referral Programme and joined the gym at OCL. He is excited about going and looking forward to making some positive changes to improve their health.

John recently said "*I love going to the gym its brilliant, I've already been 5 times and it's getting me out of the house, thank you'.*

Case Study

Alice

Alice was referred to Social Prescribing by Adult Social Care. The referral asked for support for Alice to access OT services, to supporting with financial and budgeting issues and to support her with a PIP benefit renewal. On meeting Alice, she talked to the link worker about having a diagnosis of ADHD, MS and said that she was awaiting a diagnosis of Autism, she was experiencing low mood and anxiety.

Alice talked to the link worker about her past, she has a history of childhood abuse and neglect and has lived with an abusive partner and experienced domestic abuse. Alice is currently attending psychotherapy on a weekly basis and attends a college woodwork class, she is determined to set up her own up-cycling furniture business in the near future.

Alice has two adult daughters, one who is currently living with her. Alice told the link worker that she struggles to meet people in person, due to her ADHD, low mood and anxiety issues. The link worker arranged to have regular contact with Alice via phone, text and email and meet only when necessary. Alice and the link worker started to form a plan together, the plan included:

- Support to contact OT services for an assessment on her property, Alice has had a series of trips and falls at home due to the symptoms of MS.
- Support to deal with debt and budgeting, Alice is aware of her spending habits spiraling due to impulse buying, a symptom of her ADHD. The linkworker supported Alice to access Christians Against Poverty who helped her to deal with her debt.
- The link worker also supported Alice to look at her benefits and supported her to renew her PIP application.
- The OT assessment clarified that adaptations were required to Alice's property and installed an extra stair rail and grab rails were fitted to minimise the impact of trips and falls.
- Alice's autism assessment confirmed a diagnosis and the link worker supported her to renew a PiP benefit application due to the recent diagnoses.

Alice received a positive outcome of the PIP benefit tribunal, and received an increase of award granted and this was back dated from March 2023. This has significantly relieved Alice's financial situation. Alice continues to attend college and has recently set up a website to start her up-cycling business.

Feedback

Quarter 1

Text Message from Sue...

Social prescribing is an amazing service. We are so grateful. Gemma has helped us sort all our bills and mess for Angela. Years of no bill paying etc you can imagine the nightmare. Gem sorted it all and got carers back into Angela within a weekend. No job was to big or an inconvenience even supporting us just being at the end of the phone when losing our brother over the last few weeks. We are so grateful. Thank you.

Quarter 2

Email from Margaret ...

Laura just a little update, I have moved into my new flat, at Nelson Way. I cannot believe the difference I feel I have won the lottery, everything is lovely, and I can breath more easily, also still struggling with my grief, trying very hard to move forward, I need to thank you for your support and professional advice thanks again.

In Q2 we hosted a student placement for the NHS graduate management training scheme, the student has been delivering a project to capture the voices of the individuals that have been accessing the service. The results being a co-produce piece of work that celebrates and raises awareness of Social Prescribing, while also using the opportunity through lived experience to capture successes and learning for the future: Here's some of the headlines - with more at details on our website

91% of users were extremely satisfied and very satisfied with the Oldham Social Prescribing service

100% of users would recommend the Oldham Social Prescribing service to a family member or friend

100% of users noticed a significant or slight improvement to their wellbeing since accesses the Oldham Social Prescribing service

Good service, understanding and helpful! The team have worked miracles. Can't think of anything negative about the service at all."

""Thank you for all that you did , the time spent supporting us you have taken the pressure of our current situation so thank you much!"

"You have been great! I didn't know this service existed and now I feel it's essential, not just for knowing about social activities and support groups but by addressing loneliness... it has been so helpful."