HACT whg

The ‘H’ Factor

Hope, health, and happiness: an evaluation of the social prescribing service at whg

May 2022

Contents

1. Executive Summary

1.1. Background

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

whg recognise the impact of other determinants of health for customers and communities, such as income and employment status, and the implications this has for tenancy sustainment and creating and sustaining resilience communities. As a member of the Walsall Together Board, the local Integrated Care Partnership, whg leads on the Resilient Communities workstream, which focuses on tackling health inequalities caused by the wider determinants of health. This provides whg with the opportunity to strategically influence and shape local health and social care services which are ultimately delivered to their customers.

There is a strong commitment from the whg Board and Group Executive Team to place health, wellbeing, and prosperity at the heart of the organisation and this is reflected in the Corporate Plan and specific aims to achieve by 2022:

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

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

1.2. Context

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

The service is intended to engage a broad user base, address local challenges and needs, support positive health and wellbeing outcomes, sustain tenancies and build stronger and more resilient communities. It has drawn on existing infrastructure and positioned community development and an asset-based approach as a core component of the work. In line with the objectives for whg's health and wellbeing strategy, *The H Factor,* the social prescribing service

has focused on communities with significant levels of financial deprivation and heath inequalities. As result, the service has predominantly served through living in Walsall, but not exclusively so.

Recognising the need to evidence and evaluate the impact of the service in order to support service development and growth, whg commissioned HACT to work collaboratively to:

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

The primary driver for this evaluation is to create robust empirical evidence to quantify the impact created by the social prescribing service and make a case for partnership working between whg and local health partners.

1.3. Summary of findings

Service profile

- A total of **277** customers engaged with the social prescribing service during the research reporting period.
- The majority of service users identified as **female** (**70%**) and **White British**, (**88%**) and were aged between **26-35** and **36-45**.
- On average service users attended **5** individual face to face sessions which were delivered over a period of **4.5 months** .
- Just over a third of service users (**81)** were referred to a further support service to ensure their longer-term needs were addressed.
- The 'Family and Friends' test scored **100%** and service partners were happy with the service and their collaborative working with whg.

Service impact

- **Over 90% of services users reported positive change in BCF 8 scores and WEMWBS scores** (91.7% improved BCF 8 scores and 90.8% reported a statistically meaningful positive change in their wellbeing captured using WEMWBS survey questions.
    - Average WEWWBS score before engaging with the service was **33.4** and **49** after receiving support through the social prescribing service.
    - A large proportion of service users **(87%)** reported low levels of wellbeing prior to engaging with the service, compared to 28% of service users who reported low wellbeing after receiving support. This highlights the need for the service and scope for further improvement in community and individual wellbeing within this population.
- A survey of a random sample of service users showed a significant impact of the Social Prescribing Service on **reducing pressures on primary care**, with **93%** reporting **a reduction** in the number of times they have needed to contact their GP, and **7%** reporting having **no need** to contact their GP.
- Using the data collected in the WMWBS surveys, HACT has assessed the social impact of the social prescribing service and found the **total direct social value created by the projects was £1,923,146.** This is a result of: *187 customers improving their SWEMWBS scores between the pre and post survey.*

- The social prescribing programme also supported people into regular volunteering, employment, and accredited courses:
    - 22 customer progressed into employment
    - 36 customer employment training
    - 28 customers attended accredited training courses
    - 16 customers became regular volunteers.
    - It is important to note, that whilst these outcomes are captured in the UK Social Value Bank and a social value can be attributed to this positive impact on the lives of customers, outcomes from the UK Social Value Bank cannot be used together with outcomes from SWEMWBS (Short version of Warwick-Edinburgh Mental Wellbeing Scale).

Key headlines

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

Holistic support - the service is filling a gap in wellbeing support provision using innovative and holistic approaches to working with customers, contributing towards keeping people in their home which has a huge benefit to their physical and mental health as well as engaging them in new opportunities such as training or work, which in turn generally leads to: lower likelihood of being in debt; reducing loneliness or isolation; being more effective parents; sustaining tenancies; and less need for more costly interventions within the health and social care system. The whg social prescribing service has had a life changing impact, not only on those that engage with the service but importantly, on the wider family unit, the wider community and the health and social care system by reducing the need for clinical services to intervene.

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

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

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

Dealing with consequences of COVID-19 - the suite of support provided by whg has played a key part in addressing the impact national lockdowns have on the local community, including job loss, loneliness, isolation, and increased level of anxiety related to social spaces. Many interviewed customers noted that their mental health got worse during the pandemic and not having a family or support network locally have made it a particularly difficult time. Having someone external yet based locally, therefore, had a positive impact on their lives.

Convenience - the accessibility to an array of service offerings through the team as a single point of contact was highlighted as being a key feature of the success of the service as

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

1.4. Conclusions

HACT has been impressed by the hard work and dedication of the team successfully delivering services in what was, and remains, a challenging operating environment. The research shows that whg occupies a clear and a much-needed role in the local community as a support provider. The overwhelming majority of comments in the interviews and survey were positive, with many customers referring to the positive atmosphere created by those providing the support. During the evaluation reporting period, the service has **generated £1,923,146 in social value for the wider health economy in Walsall.**

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

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

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

2. Introduction

2.1. Context

*"Health inequalities are intrinsically linked to differences in social class and income. An increasing number of **social housing tenants** are adversely impacted by the wider determinants of health. Due to inherent barriers, despite being the most in need of health services **social housing customers** often have the **least access** to services when compared to that of the general population."*

Health Equity in England: The Marmot Review 10 Years On[1]

The role of housing as a social determinant of health is well-established and recognised is a cornerstone of good health. However, the causal pathways are poorly understood beyond the direct effects of physical housing defects. This is broadly recognised by housing providers, who have a strong social ethos and commitment to helping those who are struggling with various aspects of their emotional and physical wellbeing and providing services to those who most need them yet are not receiving support from elsewhere.

Founded in 2003, whg is one of the largest providers of affordable housing in the Midlands, providing housing to almost 21,000 customers across 18 local authorities in the Walsall and Midlands area. Customers live in some of the most disadvantaged communities, where health outcomes are generally poor and there is limited access to health care services. whg plays a key role is providing health and wellbeing support in across the Midlands.

As an active member of the Place Shapers alliance of community-based housing associations, whg is committed to providing great housing, promoting good health, and helping customers and communities prosper. They are regarded as more than a landlord and making a positive impact on people's lives is at the heart of all whg's activities. As a community anchor organisation, this correlation of working within communities with entrenched health inequalities enables whg to take a leading role in addressing the challenges people face through long term investment in homes and services. In addition to their commitment to serve their communities over and above being just landlords, whg are ideally situated to work at a place-based level with the wider health and social care sector as the conduit for satisfying the holistic needs of the local population.

whg launched their social prescribing service in early 2020 to build on existing infrastructure, address needs of local communities and position community development as a core component of the work it does with customers and the communities it serves. In line with their Health and Wellbeing Strategy, *The H Factor,* the service is focussed on those communities with the highest levels of deprivation and health inequalities. The purpose of the service is to engage customers furthest away from services, support positive health and wellbeing outcomes and enhance community development.

Being uniquely placed to collaborate with whg to evaluate the social prescribing service, HACT has worked collaboratively with whg to achieve three key aims:

[1] Institute of Health Equity. Health equity in England: the Marmot review 10 years on. London; 2020. **http://www.instituteofhealthequity.org/the-marmot-review-10-years-on**

1. Independently evaluate and empirically quantify the impact achieved by whg's Social Prescribing service for service users and the organisation
2. Collate learning that can be used to shape service design, help embed a durable culture of continuous improvement going forward and make a case to local health partners for collaborative investment and partnership working
3. Capture lessons from data collection, service design and delivery to inform recommendations for future service design, monitoring, and evaluation processes.

The primary driver for this evaluation is to create robust empirical evidence to quantify the impact created by the Social Prescribing service and make a case for partnership working between whg and local health partners.

2.2. Evaluation Methods

To assess the available evidence and empirical and qualitative data from the social prescribing service, HACT configured a research model using a mix of qualitative and quantitative methods. This model effectively provides a comprehensive picture of the impact and value of the service and identifying opportunities to enhance service design and delivery. The findings are set out in detail in the following sections of this report beginning with a summary of the methods applied. Three research methods were used:

Desktop review

HACT carried out a review of key operational and strategic literature provided by whg to gain a broad understanding of whg, its customers and the service. Additional literature sourced by HACT was also reviewed to deepen understanding of the wider environment and support any observations or recommendations.

Quantitative outcome analysis

Through quantitative analysis of available reporting data, HACT has:

- Profiled service users to understand who received support
- Assessed service outputs and performance against intended outcomes and investigated the impact of additional service outcomes.
- Reviewed agreed outcome metrics and identified improvements to shape future monitoring and reporting processes.
- Assessed the social impact created by the service.

The statistical significance of the change in Warwick and Edinburgh Mental Wellbeing Scale (WEMWEBS) scores was assessed using a paired t-test that measured the significance of the difference in means of scores before and after the intervention. Descriptive statistics used in this analysis were done using Tableau software.

Social value is the measurement of the positive changes people experience that benefit the community. Increasingly much of this value can be measured in economic terms, including the direct benefit of increased value to individuals. It is important however, also to consider and measure this social value from the perspective of those in receipt of tangible long-term benefits of the work carried out by social housing providers. By measuring this before and after that individual uses a service, it is possible to quantify the wellbeing uplift created as a result of their engagement. The valuation of wellbeing can, as well as the impact on individual service users, quantify the impact generated by a service or intervention overall, by adding up the figures for all service users, to create a net social impact.

The short form of WEMWBS (SWEMWBS) uses 7 of the statements scored on the same scale. We have drawn on the data collected for these 7 questions by whg and used the wellbeing valuation method to value movements on the SWEMWBS scale. These values represent the additional money, the average individual would need to improve their wellbeing, which is the same amount as the improvement in their SWEMWBS score. More information about social value, the wellbeing valuation methodology and the UK Social Value Bank can be found in Appendix 7.

It is important to note, that the SWEMWBS measure should not be used to measure social impact in combination with values from the UK Social Value Bank. This is because SWEMWBS measures mental wellbeing and the values for the outcomes in the Social Value Bank already incorporate the impact on mental wellbeing (for instance, a person who gains employment is also likely to have lower anxiety and a person who dances frequently is likely to experience less stress due to increases in physical exercise). Adding the SWEMWBS values and the Social Value Bank outcome values would lead to double counting. The SWEMWBS values should therefore be seen as an alternative to the outcomes values in the Social Value Bank. For the purposes of calculating social value for the social prescribing programme, we have focused measuring SWEMWBS and valuing the change in SWEMWBS rather than measuring the outcomes of a programme and valuing the outcomes in the Social Value Bank.

Stakeholder interviews

This took the form of semi-structured interviews with internal and external stakeholders. Participants included 7 whg colleague members directly involved in the designing, implementation and running of the service; 3 external stakeholders from partner organisations within health and 8 service users, providing lived experience and referred into the service from other departments within whg, as well as one self-referral. More information on the interview methods can be found in Appendix 3.

HACT routinely includes qualitative data to help corroborate and enrich empirical evidence. Previous HACT research projects have been particularly useful in shaping the service user and colleague aspects of service design, bringing the statistical findings to life. Through qualitative research, HACT has captured nuanced and holistic insights about service delivery in practice from the perspectives of all stakeholders, including variances in the service model, what has worked well, challenges with delivery and data collection and perceived impact on service users.

HACT is delighted to share the outputs from this Social Prescribing service evaluation. This report is divided into key sections:

- Introduction and overview of the research methodology
- Context on the social prescribing landscape in the UK and the role of housing associations in this space.
- Overview of whg and the service, outlining key stakeholders and service user journey.
- Insights into how the service is being delivered, its outputs and outcomes based on both qualitative and quantitative data
- Summary of observations and action-focused recommendations drawn from stakeholder engagement and data analysis, aimed at informing, developing, and expanding the current service.

It should be noted that for this evaluation, the term ‘service user’ refers to those whg customers who are using the service. Not all customers are service users.

3. Drivers for the development of the social prescribing service

3.1. Social prescribing as a concept

With the development of the Social Prescribing Network[2] and collaborative working with NHS England since January 2016, social prescribing is now a key part of the government's Connected Society strategy.[3] Under the new NHS England universal personalised care strategy, social prescribing is part of a GP contract in the UK for the first time in history[4]. This represents a system-level response to tackling loneliness and social isolation, as well as reducing health care utilisation and improving health and wellbeing. Four in 10 GP's say they 'regularly' see patients who are lonely rather than in need of medical help, with 34% stating that treating lonely people had a 'major' impact on their time and NHS resources' [5]

Social prescribing is an innovation that formally links individuals with non-medical sources of support within the voluntary, community, and social enterprise sector (VCSE) to improve their long-term health and wellbeing.

Identified individuals can be referred into a social prescribing service by a link worker via a range of referral routes (e.g., primary care, secondary care, allied health, social care or statutory services)[6]. The link worker is a non-clinical person who excels at developing relationships so that people feel able to explain what is happening in their life. An initial meeting with a link worker aims to uncover a person's preferences and unmet needs. The individual is then supported to access appropriate support, usually via the VCSE[7]. Some individuals may have several consultations with the social prescribing link worker before being ready to move onto a community group or activity. The time spent building trust and agency with the link worker is seen as a key part of the social prescribing intervention. Recognising that people's health and wellbeing are determined mostly by a range of social, economic, and environmental factors, social prescribing seeks to address people's needs holistically. It also aims to support individuals to take greater control of their health.

[2] https://www.socialprescribingnetwork.com/
[3] (HM Government (2018). A connected Society. A strategy for tackling loneliness – laying the foundations for change. Department for Digital, Culture, Media and Sport)
[4] (Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan 31 January 2019 NHSE and BMA; https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf).
[5] Cogora Survey, 2019; https://www.pulsetoday.co.uk/news/uncategorised/four-in-10-gps-regularly-see-lonely-patients-whohttps://www.pulsetoday.co.uk/news/uncategorised/four-in-10-gps-regularly-see-lonely-patients-who-are-not-unwellare-not-unwell
[6] The link worker is the generic name for this role and is referred to in all national policy information about social prescribing. This is the title also used in the whg service.
[7] Kilgarriff-Foster, A., & O'Cathain, A. (2015). Exploring the components and impact of social prescribing. Journal of Public Mental Health, 14(3), 127–134. http://doi.org/10.1108/JPMH-06-2014-0027 7 Kimberlee, R. (2015). What is social prescribing? Advances in Social Sciences Research Journal, 2(1). http://doi.org/10.14738/assrj.21.80

Figure 1. Public Health and communities Gov.uk 27/1/2022

Social prescribing is designed to support people with a wide range of social, emotional, or practical needs. Many schemes are focused on improving mental health and physical wellbeing. A report in April 2021 by The Health Foundation[8] highlights the relationship between mental health and unemployment as being 'bi-directional'. Good mental health is a key influence on employability, finding a job and remaining in that job. Unemployment causes stress, which ultimately has long-term physiological health effects and can have negative consequences for people's mental health, including depression, anxiety, and lower self-esteem. Figure 2, demonstrates the prevalence of depression in whg customers.

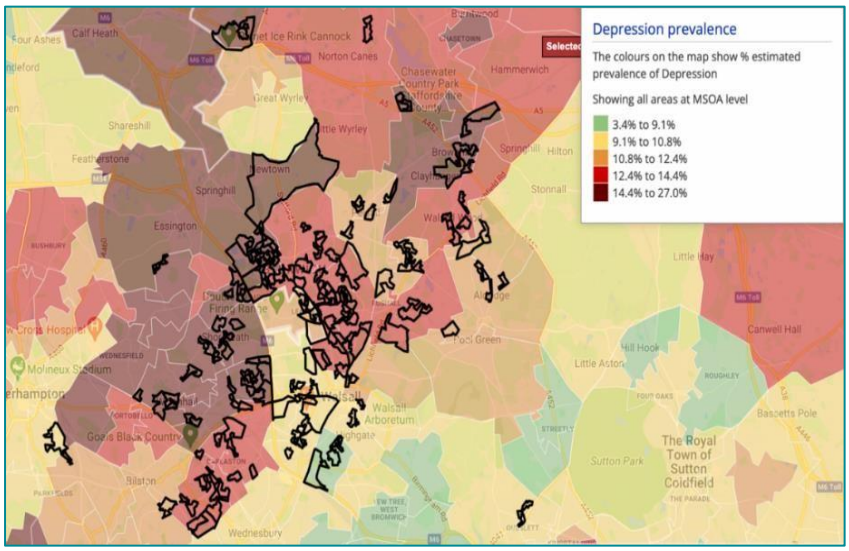

Figure 2. Depression prevalence across the areas where individuals referred to the social prescribing service live (indicated by their postcode in black area lines).

3.2. Social prescribing in practice

Schemes delivering social prescribing can involve a range of activities that are typically provided by voluntary and community sector organisations. Social prescribing can be

[8] Unemployment and mental health: why both require action for our COVID-19 recovery https://www.health.org.uk/publications/long-reads/unemployment-and-mental-health

understood as one of a family of community-centred approaches which aim to mobilise the power of communities to generate good health.

A programme in Shropshire, evaluated between 2017 and 2019, found that people reported statistically significant improvements in measures of wellbeing, patient activation and loneliness.[9] A three-month follow up, it also found that GP consultations among participants were down 40 per cent compared to a control group.

At a local level, the 'Making Connections Walsall Programme' began in October 2017 as a 2-year programme to tackle loneliness and social isolation, improve wellbeing and reduce preventable health service and social care usage.[10] As a Walsall Together project incorporating Public Health and the wider Walsall Metropolitan Borough Council, a social prescribing approach was adopted. To improve the social connectedness of older people (60+) in the Walsall area, assessing the outcomes and social value created by the programme and assessing the effectiveness using a social return on investment methodology. Early stakeholder involvement, recognition of the time needed for the programme to mobilise and qualitative evidence of 'softer' outcomes being as important as quantitative measures were all interim findings of this programme (see Appendix 4).

While their primary role is as providers of social housing, larger housing associations tend to have a remit beyond simply being a landlord. Most housing associations are committed to improving the communities in which they work and the lives of their residents. Accordingly, the sector invests around £750 million per year in its communities, of which just over £500 million is generated from their surpluses[11]. This work is generally known within the sector as community investment (though it can sometimes go by other terms such as community development, housing plus, or tenancy support). It focuses on key areas such as employment support, health and wellbeing, safer and stronger communities, physical environment, financial inclusion, and digital inclusion.

In terms of social prescribing, the work through community investment and supported housing is where housing associations most likely fit into the vision. These are the sort of services that would be extremely useful for an individual, which they could be prescribed.

In 2016, Family Mosaic (now merged with Peabody) published the results of its three-year randomised control trial (RCT), Health Begins at Home[12], which went on to be peer-reviewed and published by the British Medical Journal (BMJ) in 2018. The study tested the effectiveness of an intervention-based service model in improving the health and wellbeing for older residents. The research found that health and well-being interventions reduced demand on the NHS and improved outcomes, particularly for the vulnerable residents. Housing associations can identify and access highly vulnerable members of the community who might otherwise be forgotten, especially if they are not engaged with any existing health services or local activities. With their proximity to residents, housing associations can use their existing role as community anchors, along with the support services being provided in their role as landlords, to deliver services that can have a positive impact on the health and wellbeing of residents.

[9] Polley M, Seers H and Fixsen A (2019). Evaluation Report of the Social Prescribing Demonstrator Site in Shropshire – Final Report. University of Westminster, London.
[10] Aiken A. et al (2018) Making Connections Walsall Programme: Opportunities and challenges from implementing a Social Prescribing approach using a Social Return on Investment (SPOI) Evaluation Methodology
[11] National Housing Federation (2012) Building Futures: Neighbourhood Audit Summary and Key Findings, https://www.birmingham.ac.uk/Documents/college-social-sciences/ social-policy/IASS/research/building-futures.pdf [13]'Health Begins at Home'; Family Mosaic, 2016
[12] Dayson C. Bennett E.(2016) 'Evaluation of Doncaster Social Prescribing Service: understanding outcomes and impact' https://www.artshealthresources.org.uk/docs/evaluation-of-the-doncaster-social-prescribing-service-understanding-outcomesand-impac

Challenges facing population health in Walsall

Walsall is a metropolitan borough consisting of a mix of urban, suburban, and semi-rural communities. Covering 40 square miles, it is located to the north-west of Birmingham, and is one of the four local authorities that make up the Black Country sub-region (with Dudley, Sandwell, and Wolverhampton). Walsall town centre lies at the heart of the borough surrounded by Aldridge, Bloxwich, Brownhills, Darlaston and Willenhall district centres.

Walsall's overall population of 285,500 residents (ONS 2019), is predicted to increase by 5.9% over 10 years. Like many areas, the predicted growth of Walsall's older population (> 65) is higher than this at 12.4%. With births also on the increase in Walsall, planning to meet the needs of a growing younger population as well as a growing number of older people is incorporated within the Local Authorities' key strategic priorities.

44 of the167 neighbourhoods (LSOAs) are now amongst the most deprived 10% in England compared to 34 in 2015 The 2019 Index of Multiple Deprivation now ranks Walsall as the 25th most deprived English local authority (out of 317), placing Walsall within the most deprived 10% of districts in the country (33rd in 2015, 30th in 2010 and 45th in 2007). There are extremes of deprivation, with central and western areas typically much more deprived than eastern areas. Pockets of deprivation, however, exist even in the more affluent parts of the borough. Walsall fares particularly badly in terms of income (16th), education, skills & training deprivation (11th) and employment (38th) and many of the issues that challenge the borough match the geography of deprivation.

Insights drawn from the Community Insight analysis (see Appendix 2) suggests that unemployment is substantially higher across the areas where whg operates the social prescribing service, compared to England's average (8.2% and 4.7% accordingly). Figure 2 provides a visualisation of the areas where individuals using the service live and the levels of low employment in their area. All these factors have a significant impact on the health and wellbeing of service users, with unemployment and deprivation being key wider determinants of health, and clearly evidence the need for the Social Prescribing service that whg provides.

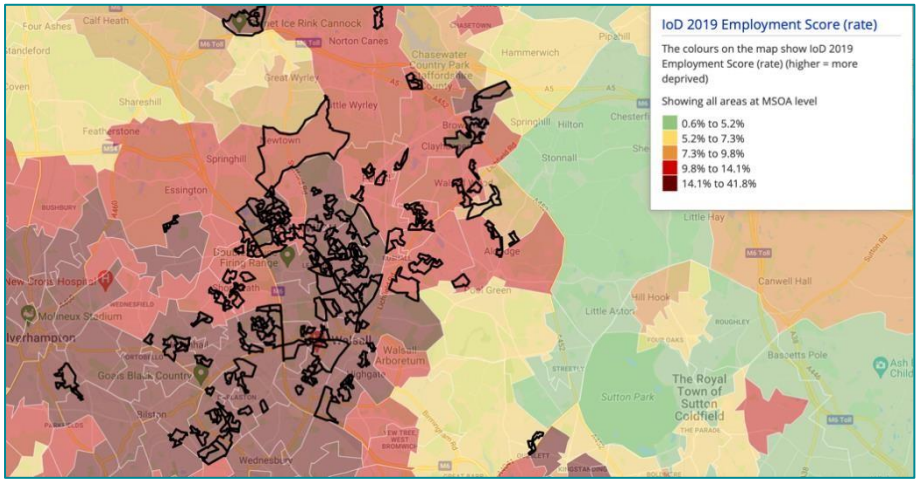

Figure 3. Levels of low employment opportunities in the areas where individuals using the service are based.

The high and increasing levels of child poverty puts additional demands on services. Walsall ranks 17th for income deprivation affecting children index (IDACI 2019), with the Borough's relative deprivation increasing over time (27th in 2015). The health inequalities in Walsall are

quite unique[13], with an East / West divide apparent in relation to some factors. The healthy life expectancy in Walsall is just 56.4 years, compared to the figure from the World Health Organisation of 73.4 years, equating to a 17-year differential. This emphasises the importance of understanding communities and being confident in addressing the wider determinants of health, with a commitment to ensuring all Walsall residents have the best possible opportunities to maximise their potential.

Many of the 'high spend' non-communicable diseases affecting the Walsall population have modifiable risk factors which, with support, a person can change. The modifiable risk factors include, obesity, high cholesterol levels, high blood pressure, physical inactivity, smoking, and excess alcohol consumption. It is also understood that when a person becomes more physically active, this will also improve other risk factors such as obesity, having multiple physical and mental health benefits. These benefits include a lower risk of cardiovascular disease, high blood pressure, breast cancer, colon cancer and delayed onset of dementia[14]. Interventions such as social prescribing can support a person to address these modifiable risk factors, have a positive impact on a person's health and well-being and reduce the usage of health care utilisation. In a review of health service usage where social prescribing schemes were implemented, a significant reduction in GP appointments, admissions to A&E, unplanned admissions to secondary care and a reduction in prescribing were all found.[15]

[13] Director of Public Health Annual Report 2018

[14] World Health Organisation (2010). Global recommendations on physical activity for health. Geneva

[15] Polley M et al (2017). A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications. Commissioned by NHS England. Download at https://westminsterresearch.westminster.ac.uk/item/q1455/a-reviewof-the-evidence-assessing-impact-of-social-prescribingon-healthcare-demand-and-cost-implications

4. Social Prescribing at whg

4.1. Service development

whg recognise the impact of other determinants of health for customers and communities, such as income and employment status, and the implications this has for tenancy sustainment and creating and sustaining resilience communities. As a member of the Walsall Together Board, the local Integrated Care Partnership, whg leads on the Resilient Communities workstream, which focuses on tackling health inequalities caused by the wider determinants of health. This provides whg with the opportunity to strategically influence and shape local health and social care services which ultimately are delivered to their customers.

The development of the Social Prescribing service was driven by whg's core social purpose and aspiration to use innovation and behavioural insight approaches, to support customers to achieve positive outcomes. There is a strong commitment from the whg Board and Group Executive Team to place health, wellbeing and prosperity at the heart of the organisation and this is reflected in the Corporate Plan and specific aims to achieve:

- Develop a place-based approach to service delivery and ensure this aligns with the 'Walsall Together' Resilience Communities priority.
- Develop strong collaborative relationships to reduce the impact of poverty for customers and communities.
- Promote health and prosperity where whg can make a difference". Be seen as 'more than a landlord' and making a positive impact on people's lives is integral to achieving this aim; playing an influential role in building healthier, more resilient and connected communities with a range of key partners – making a greater impact by working together to support residents to live safely and independently. The Resilient Communities agenda of the Integrated Care Partnership, Walsall Together, is a priority and development of the innovative Social Prescribing service to improve people's health and wellbeing supports this priority.
- Provide support and services to improve the education and employment prospects of at least 1,500 customers per year, train at least 2,000 people through the Click Start Programme, provide employment opportunities through a Housing Academy and support 10,000 to increase confidence, health, and wellbeing.
- Avoid evicting people into homelessness and transform the lives of at least 100 homelessness people by providing them a home and
- Develop an innovative Social Prescribing programme to improve people's health and wellbeing and support the 'Walsall Together' Resilient Communities priority.
- Generate social value that is equivalent to the organisation's annual turnover.

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

- Reducing the impact of loneliness and isolation on customers and communities.
- Reducing the impact of poverty on children and families living in whg properties.
- Improving the health and wellbeing of customers.
- Provide support and encouragement to enable customers to age well and live the best life possible.

The mid-pandemic refresh of Walsall Council's 2017-2019 plan, 'The Walsall Plan: Our Health and Wellbeing Strategy: 2019 -2021[16] also highlights key areas of need. These include fuel poverty, high incidence of childhood obesity and increasing mental health referrals, which demonstrate a clear need and opportunity for delivering interventions that have a meaningful impact on the lives of those communities most in need, by those who have greatest access to them.

Prior to 2020 there had been some work with residents on lifestyle factors, especially in the wake of research from Public Health showing disturbing rates of childhood obesity in Walsall, which indicated that in year 6, 26.2 % of children were classed as obese, being worse than the average in England[17]. In some areas this was as high as 46%. It is an indicator of huge ill health coming down the line and it was apparent that there was a need to work differently, and to encourage *residents* to do things differently. There was a need to create sustained behavioural change. Anecdotal evidence from informal assessment of whg tenancies appeared to correlate with health inequalities findings by Kings Fund in 2019, who expressed that:

> *'34% of people who live in social housing are adversely impacted by a long-term health condition or disability. Often leading to a lower life expectancy, a lower healthy life expectancy and an overuse and over reliance upon primary care and acute services '.*

In keeping with this, most of the subsequent social prescribing work within whg has been with those residents presenting as vulnerable (preventative intervention) and those who were managing but still requiring engagement (sustaining). With a review of the existing whg strategy[12] it became clear that an asset-based approach of community development was required.

The new NHS plan[18] which included social prescribing for the first time, provided an opportunity for whg's health team to reconfigure around this offering and 're-badge' as the Social Prescribing team. An integral part of this model was to use the successful Community Champion model to employ local people with relevant lived experience, and a connection to the communities that would be engaging directly with the service. Cultural competence is at the heart of the Community Champion model, ensuring that champions are authentic and that trust in the service develops quickly. This would prove to be the element of whg's Social Prescribing service that resonated best with the service users and partners who recognise this as the USP of whg's approach. The Social Prescribing service has a significant role to play in delivering one of whg's key strategic priorities, particularly tenancy sustainment.

A business case submission and presentation to the board in October 2019 outlined the project aim and expected outcomes (see Figures 5 and 6). whg committed investment of £200,00 and secured £100,000 of Big Lottery funding accessed through the National Lottery Community Fund as part of the organisations involvement with Black Country Futures (BCF).

[16] https://cmispublic.walsall.gov.uk/

[17] Walsall Health profile; 2019 https://fingertips.phe.org.uk/static-reports/health-profiles/2019/e08000030.html?areahttps://fingertips.phe.org.uk/static-reports/health-profiles/2019/e08000030.html?area-name=walsallname=walsall

[18] The NHS Long Term Plan 2019 https://www.longtermplan.nhs.uk

BCF is a diverse partnership of well established, community focused organisations based in the Black Country. Working together, they bring positive change to people's lives and local communities by delivering a range of support services. These services empower those who face barriers to reach their goals by facilitating access to crisis support, raising aspirations, building confidence and self-esteem, and supporting them into education, training, employment, and self-employment.

The social prescribing service at whg launched in early 2020, which coincided with the onset of the Covid-19 pandemic. The impact of Covid-19 on the service is discussed in section 5 of this report. The team began to work more strategically with partners to remove silo working. It would be imperative that the work was evidence-based for health partners to understand and acknowledge what was being achieved.

4.2. Service design

The service is designed to be delivered in those communities where health inequalities are at their greatest. Overall, the aim of the social prescribing service is to sustain tenancies, maximise income and demonstrate cost savings and help to reduce pressures on health and social care services.

The key actions initially identified to ensure successful delivery of the service were to:

- Apply an integrated work and health model as laid out in the corporate plan
- Re-shape the existing health team to focus delivery on those with the worst health and the least access to services.
- Integrate with other services delivered within whg such as employment and training, digital inclusion, money advice and independent living
- Build on the Community Champion role
- Focus on neighbourhoods and target resources where health determinants were poorest
- Use an evidence-based approach to measure outcomes Warwick Edinburgh Mental Wellbeing Scale (long) WEMWBS model
- Adapt the whg Five Step Behaviour Change Model (using Theory of Change) to incorporate health priorities (Appendix 5)

Project outcomes

The desired outcome of the service is to:

- Improve the emotional health and wellbeing, evidenced through the WEMWBS model
- Reduce the need and take-up of statutory services
- New behaviours and routines are embedded in service users, who become positive role models in their communities
- Improve confidence and capacity to access the internet and benefit from online/eLearning services e.g. My whg, pre-tenancy training, life skills
- Improve tenancy sustainment and reduce rent arrears
- Improve broader life outcomes and social determinants of health

The team uses highly reputable tools such as WEMWBS (Warwick Edinburgh Mental Wellbeing Scale) and BCF 8 assessment (Appendix 1); BCF 8 being a tool developed by funders of the service and therefore enabling standardisation across other programmes. The ongoing assessment and review of service users continues until such a point where the service user is ready for discharge. This is described in more detail in the service delivery section (3.3).

4.3. Service-user journey

Referral:

- Most referrals are internal, typically from a Community Housing Officer (CHOs), Income Collection and Money Advice and Customer Services.
- External referrals are routinely received from GP surgeries and social care and there are occasional self-referrals.
- Referrals are triaged, and the customer is allocated to a Social Prescriber who makes a phone call to the resident to book an initial meeting.
- In recognition of the many barriers that people can face to take up services where we cannot contact via the telephone the SP will routinely undertake a doorstep visit. More information on referrals can be found in section 5.1.1 of this report.

Weeks 1:

- An initial face-to-face assessment takes place typically in the customers own home, but occasionally at a neutral venue if this is better suited to the individual's circumstances.
- The team adopt the whg 'Clever Conversation' approach, with the application of coaching and motivational interviewing techniques, which enables the social prescriber to develop a rapport with the customer. Using visual cues, they will look for an obvious 'hooks' such as talking about children, pets, hobbies etc, in order to relax the individual and begin the coaching conversation. Using the 'WOOP' approach - what's your wish/outcome /obstacles/plan – the team works with the customer to identify individual issues and more importantly their strengths.
- Using a 'stages of change' approach, small SMART goals are set at this point, with referral onwards to other internal or external services if needed for: Autism; Neighbour disputes; Unemployment; Physical health problems; Hoarding; Overwhelmed with life; Debt advice; Loneliness/isolation; Un-diagnosed MH issues; Inappropriate housing; Domestic Abuse; Relationship counselling.

Week 2:

- Contact continues with the customer either via telephone or in-person visits, building trust along with assessing the progress made against their WOOP plan.
- An initial BCF 8 score (a self-assessment tool provided by Black Country Futures, being delivery partners through the National Lottery Community Fund) is recorded at week 1 and at the final visit, with an additional score being recorded mid-way if the service user's plan is expected to be in place for mid-to-long term. An example of this tool can be found in Appendix 1.

Week 3 and onwards:

- Once trust has been established, (generally after a couple of visits and several phone calls) a WEMWBS evaluation is conducted.
- The Warwick-Edinburgh Mental Well-being Scale is a scale of 14 positively worded items for assessing an individual's mental wellbeing. WEMWBS has an original 14-

item scale and a short 7-item scale and is scored by summing the scores for each of the items, which are scored from 1 to 5.

- Using the 14-question evaluation: a score of 41-44 is indicative of possible/mild depression a score of <41 is indicative of probable clinical depression.
- Using the 7-question evaluation: a score of 18-20 is indicative of possible mild depression a score of <18 is indicative of probable clinical depression.
- Following WEMWBS evaluation, a bespoke plan is created jointly with the resident, identifying any further available resources or approaches that can be utilised in order to address the identified areas of need and achieve the goals set.
- The team will continue to work with the resident until they reach their goals and feel that ongoing support is no longer required.

Discharge:

- The customer will receive a 6-month follow-up call once discharged, to assess if the resident is able to demonstrate sustainable change.
- Should they feel the need to reengage with the service the resident can do so directly, without any need to go through the referral process from the beginning.

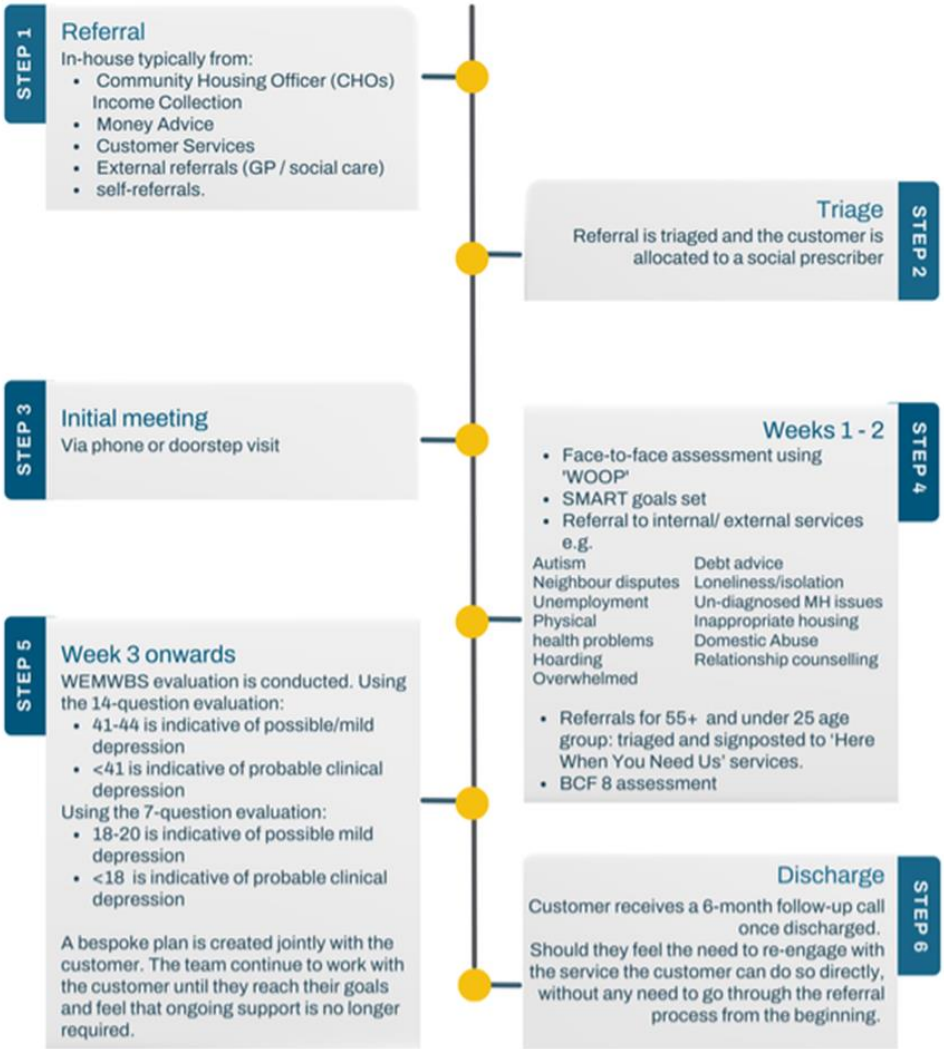


Figure 4: Service User Journey

5. Service performance

This chapter examines how the service performed in terms of engagement and positive outcomes achieved, drawing largely on quantitative data provided by whg. The evaluation reporting period covers the period from 25/06/2020 to 31/11/2021.

5.1. Engagement

Whilst serving communities across the wider Midlands area, the majority of whg properties are within the geography of Walsall - some 19,080 of 20,548 homes (93%). The image below identifies the geographical location of whg residents that have engaged in the Social Prescribing service and, as such, have been included for quantitative and qualitative analysis as part of this evaluation.

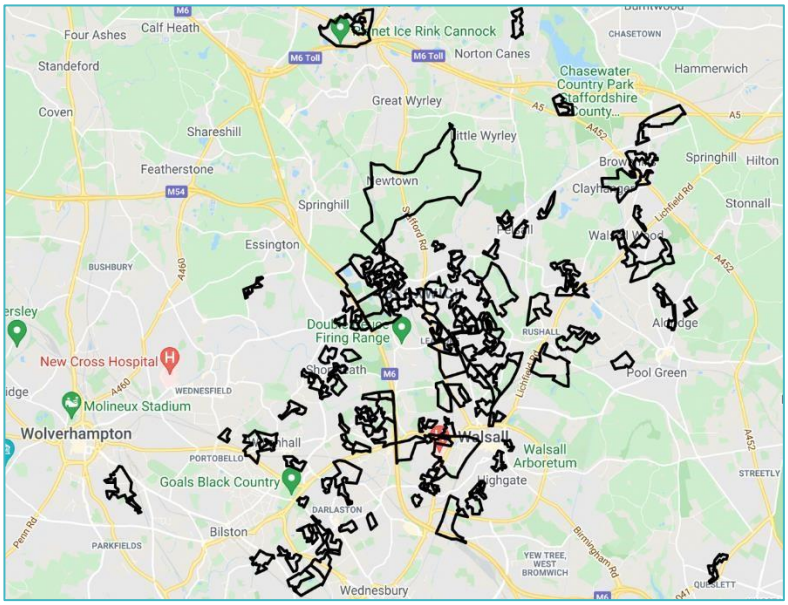


Figure 5. Geographical location of whg residents that have engaged with the Social Prescribing service

- The whg social prescribing service **engaged with 277 of customers** during the reporting period. This represents **98%** of the total number of referrals received (**283**). This included some individuals in the process of becoming whg customers due to being re-housed from other areas. Out of these, **126** have their cases closed and **101** cases were still open as of 31/1/2021.
- Average length of engagement was **145 days**, which included at least **5** one to one support sessions per client. **5.81%** of clients had more than **10** engagements.
- **19.64% of clients** had their issues addressed on the **first engagement** usually due to a problem being resolved or signposting to other services

The team reported that customers referred were in the main those who were isolated, lonely and cut-off from the community and, despite having poor health and other vulnerabilities, are not accessing other support. Rent accounts will often be covered by full housing benefit, and they will not be causing neighbours any problems. They will need help but have barriers which prevent them from accessing services. The team described them as the 'quiet' group.

A number of these were identified during the first lockdown period as part of a whg project called Stay In Stay Safe. This identified older people with a long-term health condition who lived alone and lacked support, being prioritised for assistance. Most customers had multiple reasons for referral, with the primary issues being loneliness and isolation (27.8% of all referrals), a general mental health concern (24.19%) and low confidence and self-esteem (20.94%). Table 1 details all the reasons for referrals.

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

Table 1. Referral to the service. Base: 277

The volume of reasons is expected, given that the areas where whg operate have higher than national levels of mental health related health issues. Based on the Department for Work and Pensions data from Community Insight, 4.1% of the local population are receiving PIP (Personal Independence Payment) with a mental health condition, compared to 2.3% of population across England (October 2021 data). House of Commons data shows that the estimated prevalence of depression across the areas where whg operates is higher than national average, at 13.4% compared to 11.7% of population. Most individuals referred to the service, live in areas that have particularly high prevalence of depression across the country.

5.2. Service user demographic profile

Gender profile

In terms of gender profile:

- 69.6% of residents engaged identified as female
- 30% identified as male
- 0.4% identified as transgender

Given that most referrals are related to mental health, the substantial difference between genders is expected. Men are less likely to engage with mental health services, with only 36%

of mental health referrals to NHS Talking Therapies being for men[19]. This suggests that there might be a part of the male population that is not being reached by the social prescribing service.

Age profile

In terms of age profile, the service engaged residents across all the age groups, with most people using the service in **age groups 26-35 and 36-45**.

Age group	% of total customers engaged
16-25	10.47 %
26-35	18.77 %
36-45	23.83 %
46-55	13.72 %
56-65	16.61 %
65+	16.61 %

Table 2. Age profile of residents referred to the service. B: 277

Table 2 details the age customers who were referred to the service. This directly led to the service supporting a higher number of customers aged 24-45.

By contrast, it has received less referrals for customers under the age of 25 or over the age of 45 and therefore the impact with these age groups have been less than with the 36-45 age group. This may be due to referrals received for the over 55 age group and the under 25 age group being triaged and signposted to whg' s broader 'Here When You Need Us' services. This includes a well-established Wellbeing Service, focusing on improving health and wellbeing and reducing loneliness and isolation for older customers. There is also a Young Person's Supported Accommodation Scheme', funded by Walsall Council, which helps young people sustain their tenancy and a 'Housing First Scheme' which provides support to vulnerable adults (generally males) who were previously homeless. whg' s Employment and Training Team also deliver paid work experience programmes for under 25's. Overall this results in less referrals to the SP service and therefore less engagement within the under 25 or over 55 age groups.

Without the added Here When You Need Us services the age range is particularly important, given that the literature suggests young people living independently for the first time are inexperienced with budgeting and subsequently have financial difficulties. The literature also suggests that people under 25 years, and disproportionately women under 25 years, experience quite poor mental health.

Furthermore, 75% of mental health problems are established by the age of 24[20].Therefore, early intervention is important. The SP service therefore has the potential to achieve significant impact through focussing some of their SP engagement within a social prescribing services specifically designed to support young people.

[19] https://www.mentalhealth.org.uk/a-to-z/m/men-and-mental-health
Base' refers to the sample size evaluated
[20] https://www.mentalhealth.org.uk/statistics/mental-health-statistics-children-and-young-people

Ethnicity profile

In terms of ethnicity profile, whg customers are predominantly **White British 86% and 14%** are from an ethnic minority background**.** The whg SP programme was specifically for whg customer which resulted in most participants being referred and engaged within the service from a White British background (**88.04%** of those referred to the service) which is roughly in line with whg's customer base.

Ethnicity	% of customers engaged
White British	88.04%
Black British Caribbean	3.99%
Asian British Pakistani	3.62%
Asian British Indian	0.72%
Black British African	0.72%
Mixed White/Black Caribbean	0.72%
Asian British other	0.36%
Gypsy Irish Traveller	0.36%
Mixed Other	0.36%
Prefers not to say	0.36%
White Irish	0.36%
White Other	0.36%

Table 3. Ethnic profile of residents referred to the service. Base:276

5.3. Impact

WEMWBS scores

whg collected data about the impact of the service using the Warwick-Edinburgh Mental Wellbeing Scales (WEMWBS). These were developed to enable the measuring of mental wellbeing in the overall population and are often used to measure impact of interventions as well as overall metal health in communities.

The scales rely on a survey, where individuals are asked to select one out of 5 response categories for each of the 14 items on the scale. This provides a single score that assesses the state of a person's mental health, with the score ranging from 14 to 70. To evaluate the impact of an intervention, individuals are often asked to complete a survey before and after the intervention, thus providing two overall scores. The difference in the score indicates positive or negative change to the mental health of an individual.

120 service users completed both pre- and post-intervention surveys, a response rate of 95.2%.

Overall, **90.8% of whg customers using the service reported a statistically meaningful positive change in their wellbeing**. A meaningful negative change was reported by **1.7%** of residents. The rest of the residents attained changes that were not significant or meaningful. Figure 1 details changes in the levels of wellbeing after the intervention.

Among the 120 customers who completed both surveys, the **average score was 33.4 before** the intervention and **49 after the intervention**. *WEMWBS has a mean score of 51 in general population samples in the UK* with a standard deviation of 7[21]. Although the average score

[21] https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/

for the post intervention was still below the WEMWBS average score for the UK, it is much nearer to the average for the UK population and shows a significant improvement.

The standard deviation among social prescribing service uses was 9 before the intervention and 10.2 after the intervention. This means that the scores of whg customers using the service are more dispersed and that they have more varying states of wellbeing, less clustered around the average than within the national population. In other words, there are more extremes, particularly low scores of wellbeing and higher scores after the intervention

Before the intervention, 87% of respondents reported low levels of wellbeing, reducing to 28% after the intervention (WEMWBS score lower than 43). After using the Social Prescribing service, 10% of customers reported high wellbeing, compared to only 0.8% before using the social prescribing service (WEMWBS score higher than 60).

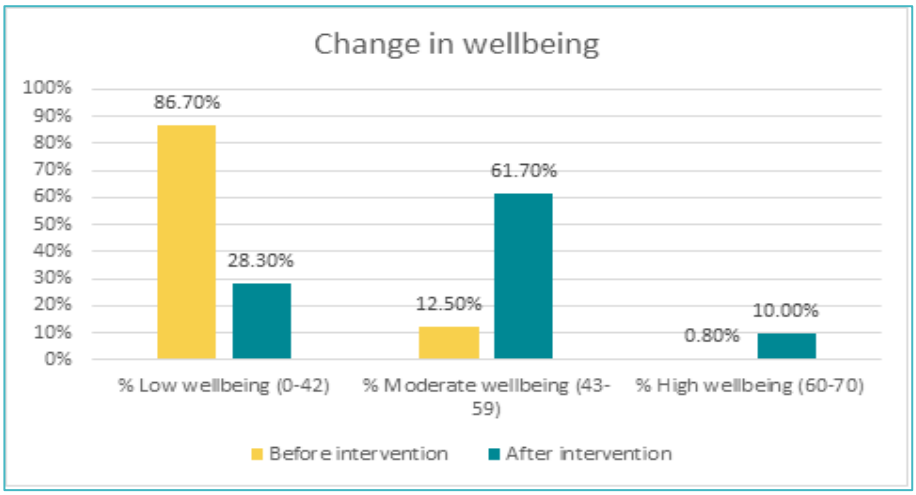


Figure 6. Changes in the levels of wellbeing before and after using social prescribing service. Base: 120

There is **no significant difference in changes in wellbeing scores between female and male service users**. When it comes to age groups, the highest average change in scores can be seen in age groups 40-54 and 55-64, suggesting that **the intervention is particularly impactful to the wellbeing of this age group.**

Age group	Before Intervention	After Intervention	Change
16-24	32.9	47.4	14.50
25-39	33.5	48.3	14.79
40-54	31.8	48.8	17.00
55-64	34.6	51.2	16.59
65+	35.3	41.6	6.24

Table 6. Average WEMWEBS scores for different age groups (base: 120)

BCF scores

168 of those using the service have completed pre- and post- BCF 8 (Black Country Futures) score assessments. This can be found in Appendix 1.

The distribution of the change in scores can be found in Table 5. **91.7 % of customers reported a positive increase in scores.** 8.33% of residents reported a negative change or no change in their scores. The average score was 15.2 and a median score was 14.

Change in BCF score	% of whg customers
<0	5.36%
0	2.98%
1-15	46.43%
16-30	33.93%
31-50	10.71%

Table 5. Change in CF scores. Base: 168

There is no significant difference in changes in BCF scores between female and male customers. However, young people saw the highest average increase in scores, an average of 20.4 points in the 16-25 age group. The average change in scores was lower in older customers.

Usage of primary and secondary health services

whg surveyed a random sample of individuals who have used the Social Prescribing Service over the past year to understand the impact that the service has on demand for primary health care services such as GPs. A total of 27 service users, or 10% of the total service user population, were engaged in the survey. Whilst this sample is not necessarily representative of the entire Social Prescribing Service user population, it does provide an insight into the impact of the service on people's lives and their need to use primary care services.

Prior to engaging with the Social Prescribing Service, the majority of survey respondents contacted their GP on a frequent basis. 67% contacted their GP monthly, 22% contacted their GP more than once a month and 11% contacted their GP on a weekly basis**. After receiving support from the Social Prescribing Programme, all survey respondents reported a reduction in the number of times they contacted their GP.** 93% of survey respondents reported a reduction in the number of time they have needed to contact their GP, with 7% reporting as having no need to contact their GP. This is a significant finding as it indicates that the Social Prescribing Services does have a positive impact on reducing the demand for support from GPs and thereby relieving pressure on an overloaded primary care system.

Mental health issues and worries about housing, family members and money feature heavily as reasons for contacting their GP frequently. Survey respondents reported depression (63%) and anxiety (19%) as the primary reason for contacting their GP, with 'other' mental health illness (11%), pain (4%) and mobility issues (4%) also reported as key issues by survey respondents. Survey respondents reported needing help with housing (45%) as being the main underlying issue they were experiencing at the time of contacting their GP. A further 15% reported bereavement, worrying about losing their job (11%), worrying about their children (11%), worried about their drinking (7%) and worried about money (7%) and weight management (4%). The data shows that needs vary across the sample, suggesting that the programme can support a wide set of support needs.

Survey respondents also reported a range of additional benefits from engaging with the Social Prescribing Programme; 15% gained employment after receiving support, 7% have entered

education and 4% have taken up a volunteer position within whg. This highlights how the service benefits people in different ways and that impact is not limited to positive changes to health and wellbeing.

Social Impact

Using the data collected in the WMWBS surveys, HACT has assessed the social impact of the social prescribing service and found the **total direct social value created by the projects was £1,923,146.** This is a result of: *187 customers improving their SWEMWBS scores between the pre and post survey.*

The social prescribing programme also supported people into regular volunteering, employment, and accredited courses:

- 22 customer progressed into employment
- 36 customer employment training
- 28 customers attended accredited training courses
- 16 customers became regular volunteers.

It is important to note, that whilst these outcomes are captured in the UK Social Value Bank and a social value can be attributed to this positive impact on the lives of customers, outcomes from the UK Social Value Bank cannot be used together with outcomes from SWEMWBS (Short version of Warwick-Edinburgh Mental Wellbeing Scale).

The SWEMWBS measure should not be used to measure social impact in combination with values from the Social Value Bank. This is because SWEMWBS measures mental wellbeing and the values for the outcomes in the Social Value Bank already incorporate the impact on mental wellbeing (for instance, a person who gains employment is also likely to have lower anxiety and a person who dances frequently is likely to experience less stress due to increases in physical exercise).

Adding the SWEMWBS values and the Social Value Bank outcome values would lead to double counting. The SWEMWBS values should therefore be seen as an alternative to the outcomes values in the Social Value Bank. Organisations have the option of either measuring SWEMWBS and valuing the change in SWEMWBS or measuring the outcomes of a programme and valuing the outcomes in the Social Value Bank.

If whg were to conduct an organisation wide impact assessment, it would be worth exploring the relationship between health, employability, tenancy services and the impact of outcomes noted in the UKSVB and measured through targeted surveys. If whg were to consider wider outcomes from the UK Social Value Bank rather than using WEMWBS, the following measures could be used to measure the social impact created by the social prescribing service:

- Employment
- Accredited training
- Good overall health
- Confidence Volunteering
- Feel in control of life
- Relief from drug/alcohol problems
- Financial comfort

- Increased access to Aids and Adaptation to ensure people remained safe and independent in their own home
- Able to pay for housing sustaining tenancies (and other financial outcomes)

5.4. Additional benefits

Although not a priority for the social prescribing service, link workers took full advantage of the benefits of having access to a skilled whg employment team, enabling effective joint working which led to 22 service users gaining employment (3 of these were employed by whg). The vast majority of those who gained employment (81.8%) were over 35 years old. In other words, the service is particularly impactful in its support for people who are joining workforce at later age or those who might be re-joining the workforce after unemployment or a career break, rather than young people looking for their first job. The average length of engagement for those who have gained employment is 129 days and average number of sessions 4.6.

28 service users received some type of training, ranging from college courses to safeguarding and first aid training. Similarly, to employment the vast majority of those receiving training were over 35 years old. It is important to note that these outcomes in part reflect the age profile of all the people engaged. The average length of engagement for those who have received training is 169 days and average number of sessions 6.

5.5. Onward referrals

The service referred 81 customers to a further support service to ensure their needs are addressed. Most of this group were referred to further employment and training services and befriending services. However, a significant proportion were also referred to various money and debt advice services (22.22%).

Further referrals	number of whg customers	% of all referred customers
Employment & training support services	36	44.44%
Befriending services	33	40.74%
Money & debt advice support	18	22.22%
Housing support	14	17.28%
Mental health support	13	16.05%
Fuel & energy	7	8.64%
Physical health (e.g. gym)	5	6.17%
Food & hardship assistance	4	4.94%
Volunteering	3	3.70%

Table 4. Referrals to a further support service. Base: 81

6. Service delivery in practice

As part of this evaluation, HACT engaged in interviews with service users, as well as whg colleague and external stakeholders, to provide insight into the practical experiences of those engaging with the service and its delivery. From these interviews, four common themes emerged: **service design; service user focus; impact of Covid-19; and partnership working**.

6.1. Service design

Interviewees from all categories were unanimous in their opinion that the Social Prescribing service at whg works extremely well. The accessibility to an array of service offerings through the team as a single point of contact was highlighted by all, providing the service user with something positive and constructive that they need, at the immediate point of engagement.

Service users (whg customers) felt that they have a confidence in knowing that they can contact their Link Worker at any time and always have someone to talk to, which adds to a feeling of being looked after and cared about. The use of local people with lived experience as Link Workers was recognised as being extremely valuable by external stakeholders and the service users themselves, as this plays a vital role in fostering engagement and developing a close relationship based on credibility and a sense of empathy; “people like us” and “being understood and not judged” were expressions used by service users. There was a very strong sense from external stakeholders that the ability to provide holistic care, with practical, physical and mental health needs all being addressed at the same time, is an extremely compelling reason for using this service; particularly as the community as a whole, it was said, has a general mistrust of all statutory services.

From within whg, the strengths of the service are its asset-based approach, being evidence based and providing people with the tools for self-empowerment and enablement. It is recognised very much as a person-centred service from the bottom-up and is seen to transform lives in a short period of time; seeing individuals achieve their goals and the impact that has, is extremely rewarding to both the team and the wider organisation.

The excellent relationship that the service has with partners was very clear to see – mutual respect and recognition of what can be achieved when working collaboratively was evident. In particular, one external stakeholder commented that the service has “connected SO MANY dots” e.g., HAF (Holiday Activities & Food programme) whereby, during lockdown, whg helped identify and deliver food parcels to families whose children normally have free school meals. As a result, uptake increased from 11% to 20%.

6.2. Service user focus

The commitment of whg to ensuring that the customer is the cornerstone of the service, is clearly a key reason for the success observed to date.

A consistent theme emerging from interviews with customers was their surprise and gratitude for the additional unexpected benefits that they gained as a result of engaging with the team. Whilst being referred for generally one specific problem, the assessment process applied went on, for many, to identify other areas where the individual had demonstrated a need, without them previously having an awareness that this need existed. This particularly came to light

during the initial Covid -19 lockdown period, through the 'Stay in, stay safe' campaign (see **Impact of Covid**, below). The services accessed following engagement were:

- Debt counselling/CAP (Christians Against Poverty)
- Foodbank
- Bereavement groups
- Befriending Services
- Training (Health and Safety, Food Hygiene)
- Clickstart digital support (enabling customer to take an Access to Healthcare course and move into employment via whg's Work 4 Health programme)
- Accessing employment

Two of those interviewed (25%) reported finding employment, which is not a key objective for the service. The needs fulfilled, both anticipated and additional to service user expectations, were reported as:

Achieved a place of safety for self and mother	Found work
Became debt-free	Increase in overall confidence
Improved mental health and wellbeing	Met a new partner after being widowed
Began volunteering for whg	Obtained training certificates to support job-seeking

Service users went on to share comments about whg such as they're "not like other housing associations" and "not just a landlord", whilst another service user suggested that the house provided by whg is "not a house anymore, it's a home".

These comments highlight the significant impact that housing providers can have on the lives of their customers. Interviews and case studies collected as part of this evaluation, suggest that the service supports individuals with maintaining independence, enabling them to stay at their home as long as possible due to sustainment of their tenancy, impacted by intervention from a variety of teams within whg. The service helps people take part in community services, particularly befriending groups that promote inter-generational dialogue and community cohesion.

One customer, a 60-year-old widower living alone and struggling to cope with the loss of his wife, told how he went from the despair of feeling that life no longer had any meaning and was in a state of contemplating suicide, to engaging with the Social Prescribing service at whg and seeing his life turn around to such an extent that he had decided to become a volunteer with the team.

"I can't wait to give back to the community that has supported me so much."

This and another case study can be found in Appendix 6.

100 % of those interviewed (8) indicated that they would recommend the service to their friends and family. Whilst a positive finding, it should be recognised that this is clearly a small sample size and not necessarily representative of the thoughts of all service users.

Inclusion means looking at 'what I need to do to enable you to thrive'. Seeing the service user in the context of their identity, family, community, and neighbourhood is important. Some

commissioners have adopted the ‘reverse commissioning approach’ which starts by looks at current levels of usage of services, then asks communities about their needs, redesigning services accordingly. The early findings from the pandemic that demonstrated that some communities were at an increased risk of ill health or death from Covid prompted whg to commit to specifically engaging with communities with a higher proportion of ethnic minority customers.

The newly emerging work within the diabetes pathway has been designed in recognition of these findings with the work, therefore contributing to improving health equity for ethnic minority customers This work is to be led by whg and funded by the Black Country West Birmingham CCG along with support from Walsall Together the place based Integrated Care Partnership

The Social Prescribing service has been the catalyst for this, with health partners seeing the work of the team reaching into communities and engaging those with the worst health and the least access to services, known as ‘double deficit’. The new programme of work will be piloted in 4 areas identified as having the most need - Birchills, Pleck, Caldmore, St Matthews and Palfrey. The Diabetes Community Health Champions are recruited from these communities, hence lived experience ensuring cultural competence and opening channels for engagement with residents who may otherwise be reluctant to come forward.

Where options are designed with the needs of communities in mind, they may help create the ‘safe spaces’ that contribute to better outcomes. It should be noted that in order to address the lower engagement in the service by its male customers whg is already planning to engage with the Clive Smith Foundation, to look at discreet work with men using sport as the hook. Section 3 of this report references some of the evidence emerging from managing the service during the pandemic and highlights research showing better engagement with services delivered digitally in young men and BAME communities. This may be something to consider in addressing the need within whg to encourage improved levels of involvement with the service.

6.3. Impact of Covid-19

General observations

Covid-19 has raised the profile and importance of this work. As customers in social housing have been disproportionately impacted by the health and economic impacts, much of the sector doubled down on its commitment to residents in a time of crisis. Mobilising rapidly, this meant an increase in welfare support and food provision alongside an adapted and expanded set of community investment activities. Through ongoing local lockdowns and the national recovery, the sector is reflecting on its role in communities. Housing associations are likely to continue to play an essential role in local areas, and collaboratively support the national recovery.

Impact on the service

Lockdown 1- early 2020: A difficult period of adjustment where face-to-face interactions ceased, being replaced by telephone calls. However, this period provided a platform to work from and served to bring health into the foreground. The Social Prescribing team were able to reach large numbers of customers and gained greater insight into their older communities (55+).

It was at this early stage of the pandemic that ‘Stay in, Stay Safe’ (SISS) was introduced, which resulted in colleagues from across whg calling 6,500 customers during the period of lockdown. These calls, made to residents aged >55, identified that a third of those spoken to

were lonely and isolated and had long term conditions or a disability, being in need of support but not meeting the threshold for adult social care.

Customers were selected to receive calls based on the government guidelines of being ‘at risk’ and rated using the RAG (Red, Amber, Green) system. Also known as 'traffic lighting', RAG ratings are used to summarise indicator values, where green denotes a 'favourable' value, red an 'unfavourable' value and amber a 'neutral' value. The ‘Stay in, stay safe’ cohort of over 55’s are supported by whg’s Wellbeing Service, which is also part of the wider Health and Wellbeing team. Support includes access to a Wellbeing Officer and bespoke accommodation along with access to an Aids and Adaptations service and a positive activities programme delivered in partnership with whg and the Community and Voluntary Sector. This programme seeks to achieve similar outcomes to the Social Prescribing service using the PERMA model of wellbeing. However, as the SISS work identified over 2,000 customers aged 65 and over who were lonely and isolated and had a long-term illness or disability, whg recognised a need to support this age group in a targeted way.

whg successfully levered in funding from NHS charities which enabled recruitment of a specific team of Kindness Champions to support the over 65s. The needs of this age group are now being met by the Health and Wellbeing Service, but by a different team to that delivering social prescribing. There is also a pathway to local befriending services for this age group.

Mid-Covid: Face-to-face visits were re-introduced, which was welcomed by customers However, many community-based services were either unavailable or heavily backlogged, which continued to impact on delivery of all services.

An increase in mental health issues has been seen throughout the pandemic, along with increased demands of the double- deficient (i.e., food and fuel), some of which were eased by new interventions such as:

- supply of Kindness bags, food, therapeutic bags, and digital provision for customers, funded by a donation from the Barclays COVID-19 Fund
- ‘Well & Warm’: warm meals, bed clothes and fuel vouchers were supplied to customers of any age, with the aim of reducing avoidable deaths caused by the cold weather
- A hot meal service for those aged 65 and over was provided for a week over Christmas 2020 and was repeated in 2021 for people who lived alone and in previous years would have had their Christmas meal at a local Charity or community organisation.

Whilst some customers struggled and were unhappy that face-to-face interventions had to cease during the early stages of the pandemic there was, overall, a total understanding of the reasoning for this action. Probably the greatest impact of this operational change was seen amongst colleagues. Whilst working remotely in isolation whilst managing a steep rise in service demand proved challenging at times and different, a culture of ‘we are all in this together’ emerged, ensuring that the whole of whg and the Social Prescribing team mobilised and supported the delivery of this new and much needed service

It is testament to the commitment of the team to their customers and the high levels of collaboration and support amongst colleagues, that this new and evolving service was able to transcend the challenges of a global pandemic to serve its local community in the very best way possible.

The success in the ability to reach the most vulnerable customers provided health and social care agencies with a new understanding of the role that Housing Associations play in health development and has been the catalyst for emerging collaboration.

Impact on the organisation

A continued lack of the external resources needed to deliver services across the whole of whg, generated an enhanced need for creativity. This included working closely with whg's *ClickStart* team in a bid to tackle the insufficient digital provision that was being seen amongst many residents, allowing the movement of some services online and the distribution of tablets to some service users. This enabled them to engage with the Social Prescribing team, to reduce their loneliness and isolation.

Information shared during the interview process also highlighted an amendment to procedures relating to rent arrears. Since the onset of the pandemic, the Income team has introduced *'Collection with Care',* which involves asking customers questions around wellbeing rather than finance. This is clearly aligned to the approach of the Social Prescribing service **and has led to the Income Collection team increasing referrals to the service.** There has been minimal evicting into homelessness, with just 3 evictions in the last year, out of 20,000 residents.

The flexibility and creativity demonstrated throughout the pandemic, shows whg investing resources to help improve customer's lives. Since the Social Prescribing service was introduced, whg have received funding from the BCWB CCG to replicate the work of the social prescribing service focussing upon people at risk of or impacted by diabetes The new whg Community Health Champion service will adopt the principles and approach within the NHS 'Core20PLUS5', to facilitate collaborative cross-sector partnership working across housing and health. This approach is designed to support Integrated Care Systems (ICS) to drive *targeted* action in health inequalities improvement.

Figure 7. CORE20 PLUS 5: NHS

Ongoing effects of Covid-19; learnings from whg

Evidence continues to emerge concerning the direct and indirect health and community effects of COVID-19, and the significant burden it has placed on vulnerable groups including those with pre-existing health conditions[22]. This evidence highlights race and ethnicity as significant factors in COVID-19-associated morbidity[23] and the widening gap between different communities and social groups in the United Kingdom[29]. With its aim of addressing individual

[22] Fixsen, A, Polley, M. Social prescribing for stress related disorders and brain health. Int Rev Neurobiol 2020; 152: 237–257.; Pierce, M, Hope, H, Ford, T, et al. Mental health before and during the COVID-19 pandemic: a longitudinal probability sample survey of the UK population. Lancet Psychiatry 2020; 7(10): 883–892This)

[23] Khunti, K, Singh, AK, Pareek, M, et al. Is ethnicity linked to incidence or outcomes of covid-19? BMJ 2020; 2020: 369) [29] Babbel, B, Mackenzie, M, Hastings, A, et al. How do general practitioners understand health inequalities and do their professional roles offer scope for mitigation ? Constructions derived from the deep end of primary care. Crit Public Health 2019; 29(2): 168–180; Bleich, SN, Jarlenski, MP, Bell, CN, et al. Health inequalities: trends, progress, and policy. Annu Rev Public Health 2012; 33: 7–40.)

health and wellbeing issues related to social, economic, and psychological circumstances, social prescribing presents a number of advantages in the wake of the pandemic and has a greater than ever importance moving forward, as the long-term physical and mental health impact of Covid-19 continue to emerge. The launch of the additional diabetes health champion service targeting people from an ethnic minority background will address some of the health inequity highlighted during the pandemic.

Whilst many people were enjoying the quiet and relative tranquillity of lock-down, for others it was a very difficult time. Quiet or solitude were not welcome companions and others were locked down in households without private space or even hostile environments. Indeed, in line with national reports, whg recorded a 38% increase in referrals for Domestic Abuse at this time. As a reflection of this, the Social Prescribing service is now embedded as part of the support offered to customers who are impacted by Domestic Abuse; in particular during the initial period following their move, when they may require additional support to settle following an often-traumatic period.

The quick adaptation to new forms of delivery such as video calls was invaluable for many service users. Whilst this has brought challenges, discussions with service managers has also revealed new opportunities and positive experiences with this new way of operating. In the rush to get back to 'normal', it is important that we do not lose sight of learning from this period.

Despite this being a new service at the point of the first lockdown, there was a consensus amongst whg colleagues and external stakeholders that services adapted well to the shift to remote delivery. There were concerns about how services and the type of support offered would translate and land with service users remotely. However, colleagues generally felt that they were able to help people and services worked well in this new delivery format.

The COVID-19 global pandemic has shown the importance and potential of digital tools to offer support and care in times of need. Many people using services are now realising the full potential of these digital tools.[24] whg's experience of the pandemic and its impact reflects similar findings of other housing associations such as A2Dominion[25] and Town and Country Housing[26], who have evaluated their COVID-19 response.

In part this move has been accelerated by the need to find alternatives to in-person and face-to-face visits at a time when the Covid-19 pandemic made this impossible. A survey of 2,200 people working across six countries showed that since the beginning of the Covid-19 pandemic there has been a considerable increase in the use of digital tools and platforms to deliver mental health services for example. 60% reported improved access to care and 65% reported that solutions have led to better outcomes for service users[27]. Some groups particularly have been shown to prefer on-line services such as young people from BAME communities and young men[28].

In recognition of the new normal the social prescribing programme will continue to offer online support where customers prefer this method of contact. It is an approach embedded within

[24] Cross Country Analysis: how are countries using digital health tools in response to Covid-19? countrieshttps://analysis.covid19healthsystem.org/index.php/2020/04/28/how-are-countries-using-digital-health-tools-inresponding-to-covid-19

[25] https://hact.org.uk/publications/spelthorne-community-support-hact-evaluation/?search=p

[26] https://hact.org.uk/news/keeping-it-local/?search=c

[27] https://www.imperial.ac.uk/news/212113/digital-shift-during-covid-19-benefitted-patients/

[28] Young Minds. (December 2014). Report on Children, Young People and Family Engagement for The Children and Young People's Mental Health and Wellbeing Taskforce.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/413411/Young_Minds.pdf

the health coaching programme in recognition that there are many excellent e health online services that whg customers and other residents can benefit from.

Partnership working

The social prescribing team is encouraged to be 'strong and bold' in its partnership working. Within the wider organisation the Social Prescribing service is seen as positively impacting the rest of the business, setting them aside from other providers and "avoiding that 'quick fix' image, which can often be the perception of housing associations". The team also prides itself on there being no 'preciousness' about its work; with the service user at the core, the most important thing is that the right help is delivered at the right time, by the right people – be they from within or outside of whg.

The excellent relationship that the service has with partners is very clear to see – mutual respect and recognition of what can be achieved when working collaboratively was evident.

That is not to say that there have not been some challenges along the way. At present there is no accepted Walsall model of SP however following the end of the focus upon COVID-19 work has now begun under the umbrella of Walsall Together to agree an evidence framework and shared outcomes which are aligned regardless of the organisation who are providing the SP service.

External partners highlighted the following as key reasons for working with the social prescribing team:

- Low trust in services, which can reduce take up of services by some
- The need to create community capacity, people who have the highest need often have the least opportunity to access services
- The importance for Public Health students to understand the role of social prescribing in population health, as well as the role that housing associations can play in the wider health and social care system.

One of the many positive outcomes reported during the interview process was, indeed, that Public Health students in Birmingham report that they consider working for a housing association as being an area where they can impact population health and would consider this as a career opportunity. This was recognised as an extremely positive outcome from the lead for Public Health Undergraduate and Masters courses at Birmingham City University.

One of the main areas that some internal and external stakeholders perceive to be a challenge is in getting health bodies to understand the benefits of working with housing associations. However, with the evolving ICS landscape, and the emerging success of whg health and wellbeing initiatives there is increased understanding of the important role that housing plays in health prevention and health development with a clear upward trajectory. Supported by the full integration of new Community Housing Officers, to ensure appropriate referrals, there is an expectation that the place of whg in the health of its service users will head only in an upward direction. Indeed, as a testament to the high level of knowledge and expertise demonstrated through the delivery of the service and the seamless partnership working that this has necessitated, whg has a unique position in sitting as part of the Integrated Care System/Integrated Care Partnership. This places whg in a very strong position as sector leaders in this space, at a time when health and housing formalise their relationship within the Integrated Care Systems.

7. Summary and recommendations

7.1. Summary

The primary driver for this evaluation is to create robust empirical evidence to quantify the impact created by the Social Prescribing service and make a case for partnership working between whg and local health partners. Drawing from qualitative and quantitative data, the social prescribing service made a substantial impact to the lives of service users, including:

Service user profile:

- **Engaging 277 residents** during the reporting period.
- The majority of residents referred to and engaging in the service were **female** (70%)**,**
- **White British**, 87 % and 13% Ethnic Minority background, which is in line with whg's customer demographics
- **Key age groups** all age groups worked with but higher numbers of those aged between **26-35 and 36-45**.
- Average length of engagement was **145 days, averaging support of 5 sessions** per service user.
- **81 (a third of residents) were referred to a further support service** to ensure their longer-term needs were addressed.
- The 'Family and Friends' test scored **100%** and service partners were happy with the service and their collaborative working with whg.

Service impact

- **90.8% of respondents to the WEMWBS survey questions reported a statistically meaningful positive change in their wellbeing.**
    - Average WEWWBS score before engaging with the service was **33.4** and **49** after receiving support through the social prescribing service.
    - A large proportion of service users **(87%)** reported low levels of wellbeing prior to engaging with the service, compared to 28% of service users who reported low wellbeing after receiving support. This highlights the need for the service and scope for further improvement in community and individual wellbeing within this population.
- **91.7 % of service users reported a positive increase in BCF 8 scores.**
- **22 service users** progressed into **employment**, **36 service users** received **employment training**, and **28 service users** attended **accredited training courses**
- A survey of a random sample of service users showed a significant impact of the Social Prescribing Service on **reducing pressures on primary care**, with **93%** reporting **a reduction** in the number of times they have needed to contact their GP, and **7%** reporting having **no need** to contact their GP.
- **A total direct social value** of **£1,923,146** was created

Key headlines

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

Holistic support - the service is filling a gap in wellbeing support provision using innovative and holistic approaches to working with customers, contributing towards keeping people in their home which has a huge benefit to their physical and mental health as well as engaging them in new opportunities such as training or work, which in turn generally leads to: lower likelihood of being in debt; reducing loneliness or isolation; being more effective parents; sustaining tenancies; and less need for more costly interventions within the health and social care system.

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

Both the quantitative and qualitative analysis presented in this report evidence the **lifechanging** impact that that the whg Social Prescribing service has, not only on those that engage with the service but importantly, on the wider family unit. whg customers interviewed as part of this evaluation had a universal appreciation of the value and quality of the service provided, with high levels of respect for the team delivering the service. Interviews with staff and service users uncovered powerful stories of how the interventions of the team, quite literally, saved lives on occasion but overall, transformed houses into homes and gave meaning and hope to live once again.

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

Convenience - the accessibility to an array of service offerings through the team as a single point of contact was highlighted as being a key feature of the success of the service as customers can receive something positive and constructive at the immediate point of engagement. People in need of support often feel that they are constantly moved from one service provider to another and are reluctant to trust new services or officers. The social prescribing service stops customers going through “revolving doors” and saves time for both the customer and whg colleagues.

Customers who have never previously engaged with support services may trust their landlord with an initial referral as a customer already has a relationship with them. Referrals are effective partly because they are made by whg colleagues who already know residents. This also improves the relationship residents have with their landlord that may prevent future support needs or address them early.

Effective partnership working – it is clear that whg places a strong focus on collaborative partnership working. Colleagues across the business view local partnerships as being instrumental to enhancing service offers, improving customer outcomes, developing local influence, and establishing whg as a long-term stakeholder in local communities. Colleagues

also recognise the benefits of reciprocal working and the value of working strategically with both smaller locally based agencies and larger players such as health and Local Authorities. The excellent relationship with partners is very clear to see, with one external stakeholder commenting that the service has “connected SO MANY dots” and enabled them to enhance how they work.

As of April 2022, there will be a mandatory social value weighting of 10% for all NHS procurement. NHS organisations will be required to take social value into account when procuring goods and services under plans drawn up by sustainability chiefs. As Integrated Care Systems continue to evolve, health bodies and housing associations are already on a journey of increased collaboration and partnership. In order to fulfil the new procurement criteria, it is essential that any organisation looking to work closely with the NHS has the ability to ‘monetise’ its offering through the lens of social value. HACT recommends that whg shares with funders and partners the value of the improvements that are seen in those customers who engage with the Social Prescribing service.

Dealing with consequences of COVID-19 - the suite of support provided by whg has played a key part in addressing the impact national lockdowns have on the local community, including job loss, loneliness, isolation, and increased level of anxiety related to social spaces. Many interviewed customers noted that their mental health got worse during the pandemic and not having a family or support network locally have made it a particularly difficult time. Having someone external yet based locally, therefore, had a positive impact on their lives. Despite the immense pressures of the Covid-19 pandemic, the service continued to grow and succeed, mobilising colleagues to reach 6,500 whg customers during lockdown through the introduction of the ‘Stay in, stay safe’ initiative, engaging with vulnerable members of the community that other services had been unable to reach and support. However, during this time it also became clear that there were still cohorts who were in need, but not engaging with the service – primarily men and to a certain extent, minority groups.

1.1. Conclusions

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

This evaluation provides a solid indication of key benefits as well as the main challenges of the service. During the evaluation reporting period, the service has **generated £1,923,146 in social value for the wider health economy in Walsall.** The overwhelming majority of comments in the interviews were positive, with many customers referring to the positive atmosphere created by those providing the support.

Social housing residents and other vulnerable individuals are still living in the aftermath of the pandemic and have an increased level of financial, employment, mental health and tenancy management needs. This situation is exacerbated by the depleted resources in other community services, including support provided by large national charities. whg, therefore, fills a gap in support services, providing impactful, consistent, and highly professional service that ranges from low-level support to more intensive ‘hand-holding’ support that aims to develop sufficient levels of confidence and independence. However, the impact of this should not be underestimated due to such a gentle and caring phrase as ‘hand-holding’. The social prescribing service is well placed to respond to the current cost of living crisis which will no doubt increase demand on this important service.

The service has clearly improved the health and wellbeing of the people engaging within the service with many examples of service users developing the behavioural changes and

resilience needed to cope with issues such as bereavement, debt, loneliness and isolation and domestic abuse all of which could possibly have ended up within primary care to manage. This is significant in an area such as Walsall, where health inequalities are persistent and unfair, sometimes leading to early death or a younger healthy life expectancy.

The research shows that whg occupies a clear and a much-needed role in the local community as a support provider.

One of the outstanding features is that whg has a unique position in sitting as part of the Integrated Care System/Integrated Care Partnership. **This places whg in a very strong position as sector leaders in this space, at a time when health and housing are formalising their relationship within the Integrated Care Systems.**

HACT has identified one key opportunity and recommendation for the service – **expansion.** whg currently fund the social prescribing service directly from social housing rental income. Although there is undoubtedly more demand for the service than the team can currently manage, it is recognised that there is limited capacity for whg to expand this service further without securing external funding from partners in order to facilitate this. The service is, in our view, achieving some astonishing results that benefit the wider strategic partnership and it is therefore our recommendation that whg, at the earliest opportunity, should commence strategic discussions with partners about how this service could be expanded.

1.2. Acknowledgements

The HACT team would like to extend its thanks to Connie Jennings, Lisa Sylvester and Stacey Foster for welcoming and coordinating our engagement with whg during this evaluation.

We would also like to thank the wider colleague team and Leadership Team for their openness and guidance, which has been invaluable in shaping this report. We would particularly like to acknowledge those engaged in the stakeholder interviews, who have been extremely candid and willing to share their observations and experiences. It should not be understated, the extent to which this helps form an extraordinarily solid foundation to create the right conditions for whg to achieve its goals and optimise services to residents.

Last, but certainly by no means least, the HACT team would like to offer sincere thanks to the service users who very kindly gave up their time to speak to us as part of this evaluation process. It was instantly clear as to the respect and gratitude that the residents spoken to have for the Social Prescribing team and indeed, for whg as an entire organisation. Providing homes, not houses, is how residents perceive whg and hearing them relate their stories has been both extremely pleasurable and memorable.

HACT is delighted to continue engaging with whg moving forward as a critical friend; providing support, as requested, in their commitment to continuous improvement.

Appendix 1

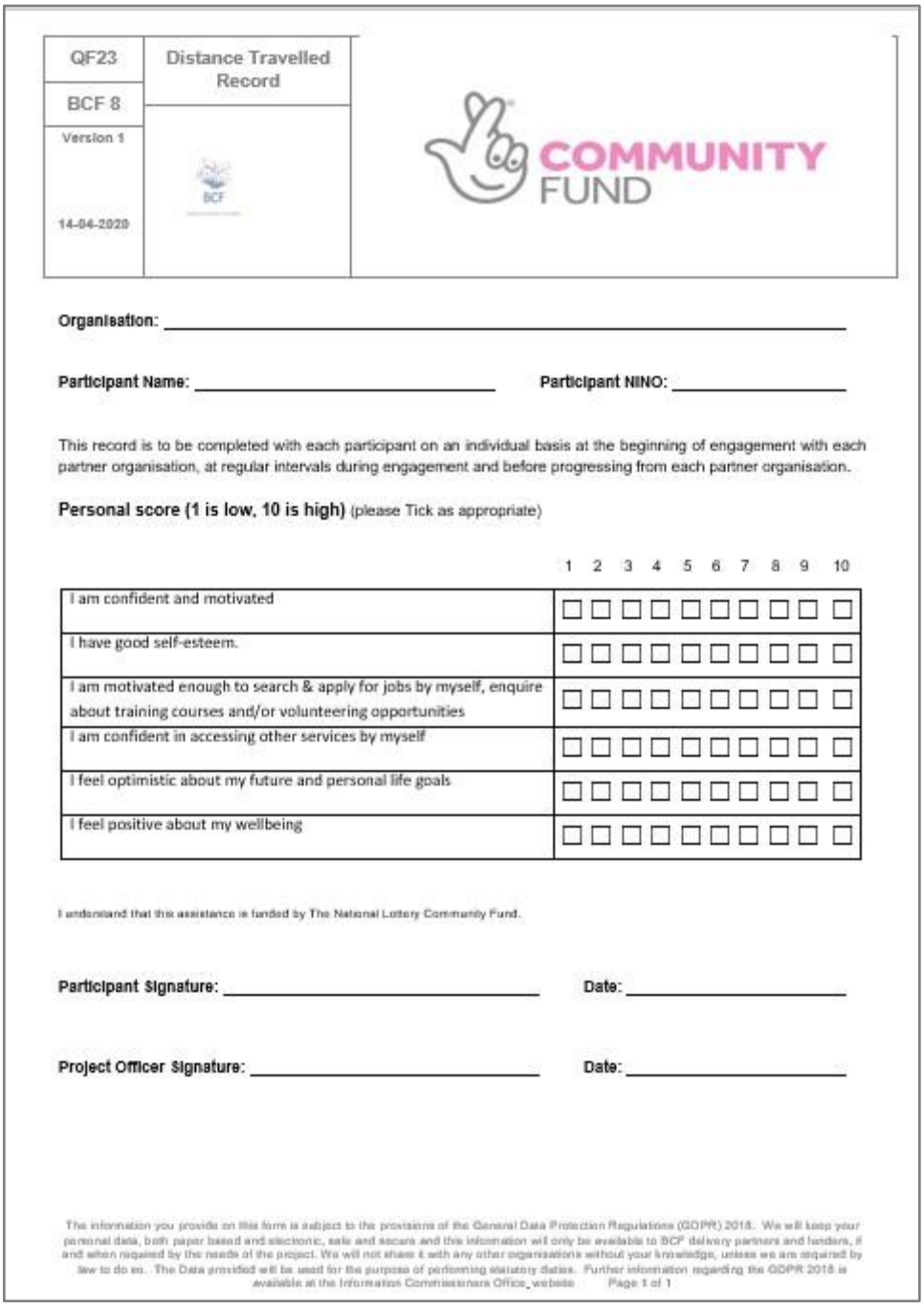
Appendix 1. WEMWEBS and BCF 8 self-assessment tools

The Warwick–Edinburgh Mental Well-being Scale (WEMWBS)

Below are some statements about feelings and thoughts.
Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

Warwick–Edinburgh Mental Well-being Scale (WEMWBS)



QF23	Distance Travelled Record
BCF 8	
Version 1	
14-04-2020	

COMMUNITY FUND

Organisation: _____

Participant Name: _____ **Participant NINO:** _____

This record is to be completed with each participant on an individual basis at the beginning of engagement with each partner organisation, at regular intervals during engagement and before progressing from each partner organisation.

Personal score (1 is low, 10 is high) (please Tick as appropriate)

	1	2	3	4	5	6	7	8	9	10
I am confident and motivated	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
I have good self-esteem.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
I am motivated enough to search & apply for jobs by myself, enquire about training courses and/or volunteering opportunities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
I am confident in accessing other services by myself	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
I feel optimistic about my future and personal life goals	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
I feel positive about my wellbeing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

I understand that this assistance is funded by The National Lottery Community Fund.

Participant Signature: _____ **Date:** _____

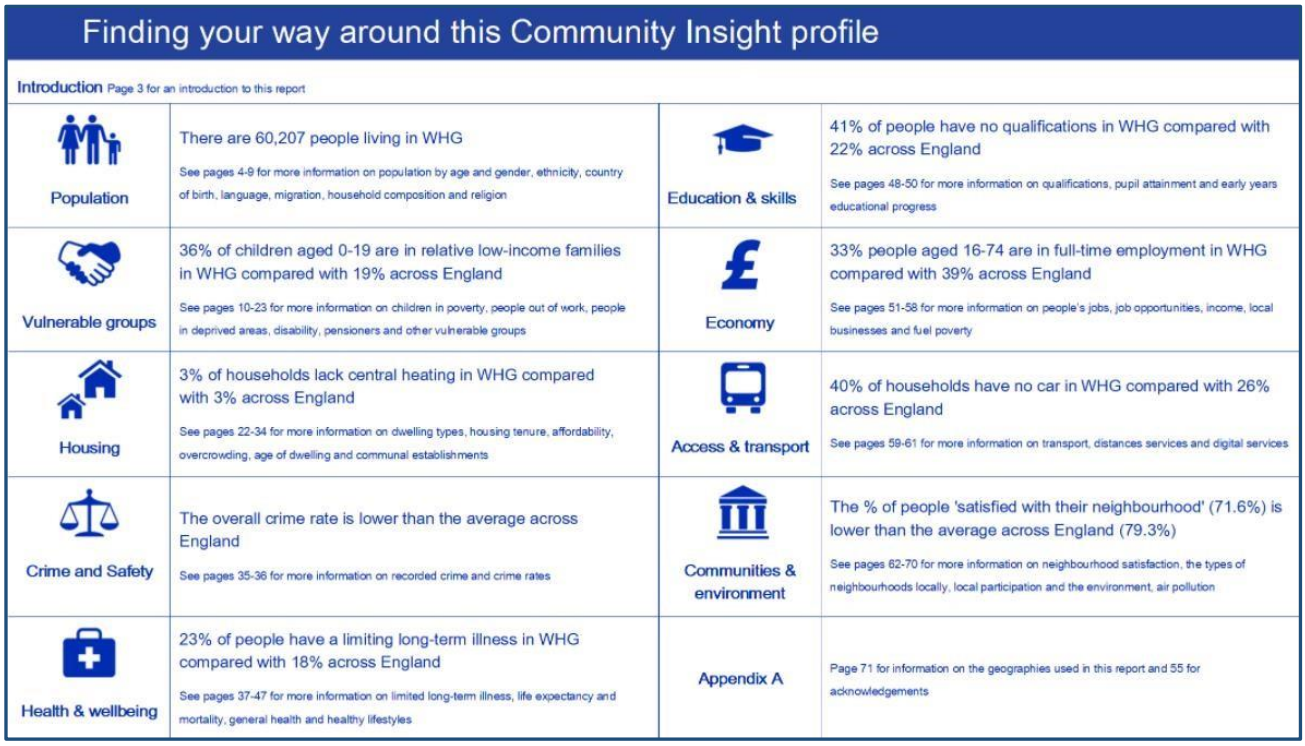
Project Officer Signature: _____ **Date:** _____

The information you provide on this form is subject to the provisions of the General Data Protection Regulations (GDPR) 2018. We will keep your personal data, both paper based and electronic, safe and secure and this information will only be available to BCF delivery partners and funders, if and when required by the needs of the project. We will not share it with any other organisations without your knowledge, unless we are required by law to do so. The Data provided will be used for the purpose of performing statutory duties. Further information regarding the GDPR 2018 is available at the Information Commissioners Office website. Page 1 of 1

The BCF 8 assessment is designed using OUTCOME STARS, a tool for measuring wellbeing. The descriptors selected measure a journey of change. Outcomes listed in the BCF8 are linked to the STAR OUTCOME framework of wellbeing.[29]

[29] https://www.outcomesstar.org.uk/

Appendix 2. Customer Insight Report – overview



Finding your way around this Community Insight profile

Introduction Page 3 for an introduction to this report

Population	There are 60,207 people living in WHG See pages 4-9 for more information on population by age and gender, ethnicity, country of birth, language, migration, household composition and religion	Education & skills	41% of people have no qualifications in WHG compared with 22% across England See pages 48-50 for more information on qualifications, pupil attainment and early years educational progress
Vulnerable groups	36% of children aged 0-19 are in relative low-income families in WHG compared with 19% across England See pages 10-23 for more information on children in poverty, people out of work, people in deprived areas, disability, pensioners and other vulnerable groups	Economy	33% people aged 16-74 are in full-time employment in WHG compared with 39% across England See pages 51-58 for more information on people's jobs, job opportunities, income, local businesses and fuel poverty
Housing	3% of households lack central heating in WHG compared with 3% across England See pages 22-34 for more information on dwelling types, housing tenure, affordability, overcrowding, age of dwelling and communal establishments	Access & transport	40% of households have no car in WHG compared with 26% across England See pages 59-61 for more information on transport, distances services and digital services
Crime and Safety	The overall crime rate is lower than the average across England See pages 35-36 for more information on recorded crime and crime rates	Communities & environment	The % of people 'satisfied with their neighbourhood' (71.6%) is lower than the average across England (79.3%) See pages 62-70 for more information on neighbourhood satisfaction, the types of neighbourhoods locally, local participation and the environment, air pollution
Health & wellbeing	23% of people have a limiting long-term illness in WHG compared with 18% across England See pages 37-47 for more information on limited long-term illness, life expectancy and mortality, general health and healthy lifestyles	Appendix A	Page 71 for information on the geographies used in this report and 55 for acknowledgements

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Appendix 3. Interview process.

Internal and external stakeholders were provided with information regarding the reasoning and process for the interviews, providing availability for a remote 'Teams' interview, due to ongoing Covid-19 restrictions. The interviews were recorded in all cases with the participant's consent. Prior to service-user interviews, all residents were provided with information and/or had the process explained to them by whg colleague. Participants then provided written consent to take part. Interviews were held over the telephone due to ongoing Covid-19 restrictions and participant convenience.

Topic guides were employed so that participants could feel free to relate their stories and unanticipated issues could emerge. All participants were debriefed and thanked, interview data were transcribed and stored securely on a password-protected computer. All recordings were deleted.

The average duration of internal/external stakeholder interviews was 57 minutes, with service-user interviews lasting an average of 21 minutes.

Appendix 4

Making Connections Walsall Programme

Appendix 5

5-Step Behaviour Change Model

PRECONTEMPLATION
Build awareness for my need to change

CONTEMPLATION
Increase my pros for change
and decrease my cons

PREPARATION
Commit and plan

ACTION
Implement and revise my plan

MAINTENANCE
Integrate change into my lifestyle

Appendix 6. Case studies

Real-world case studies provided by whg

Case Study 1

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

Initial WEMWBS 42

Final WEMWBS 66

Economically inactive 16 years

The power of Social Prescribing

From whg customer to whg colleague

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

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

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

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

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

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

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

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

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

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

Case Study 2

"I can't wait to give back to the community, who has supported me so much".

- Time spent on the Social Prescribing Programme 11 months
- Key issues , bereavement, loneliness and isolation , debt .
- Initial WEMWBS Score **20** – End WEMWBS Score **54**

RE is a 60-year-old white British male, who lives on his own in a 2-bedroom house in East Walsall .

He was referred to Social Prescribing due to bereavement . His wife had recently passed away and he was really struggling. He explained to me that his wife did everything in terms of budgeting and paying bills, so he was getting into a difficult situation with his finances. He stated he was lonely and feeling like there was nothing positive to look forward to. He reported he was very anxious and depressed and had an overall feeling of not being able to cope.

My first contact with RE was during a period of lockdown so face to face visits were not taking place at the beginning. I started to call RE on a weekly basis and began to get to know him . As trust developed, we completed the first WEMWBS scale with RE scoring **20.** I was very concerned about this as without support, he could move into clinical depression .

We talked about the loss of his wife and how bereavement counselling might help him. He agreed to a referral, but we were told that there was a lengthy waiting list for this service. I therefore provided him with information about Walsall Talking Therapies, and he agreed to a referral . This resulted in him having weekly counselling sessions which quite quickly improved his mood and overall wellbeing

RE can drive and loves getting out and about in his car we talked about how this could be used to help him, and others and he began to take family and friends to appointments . This act of kindness has helped him and others increasing his feelings of being useful and finding a new purpose in life .

We talked about his feelings of loneliness and I suggested he might benefit from a weekly call from a local befriending service . They began to call him on a weekly basis. This contact with others really lifted his mood and confidence and he began to look forward to the calls .

Now his mindset was more positive we talked about his finances which he was struggling to manage . He has several illnesses (Heart condition, high blood pressure, arthritis, depression, anxiety and memory loss) . I therefore talked to him generally about health-related benefits . With his permission I referred him to our money advice team to help him apply for Personal Independence Payment and other benefits. I also secured a £200 grant towards his heating bills from LEAP .

As the financial pressure reduced, RE began to feel more positive and with support enrolled as a volunteer befriender using his recent experience to listen to others and encourage them to try new things and get out of the house .

He also plays the guitar and has now joined a music group something he looks forward to each week He has now volunteered for over 6 months making over a 100 calls to other people who feel lonely . He has a new routine and is beginning to build a new life without his wife . He misses her but has a spring in his step .

Appendix 7

Social value

In an increasingly socially responsible world, organisations are seeking to understand the impact of their work on society. Social value is a measurement of the benefits of the work you do, the services you provide and the programmes you deliver for people and communities. It is essentially the quantification of the relative importance that people place on the changes they experience in their lives through changes in wellbeing and this value is captured and presented in different ways, including market value. It is important to recognise that social value places focus on understanding need and change from a person-centred perspective, specifically those affected by an organisations' work and services.

At its most basic level, social value is about understanding, planning, delivering, and evaluating your services and impacts to learn and provide more effective social outcomes.
It should be remembered almost everything you do has a social value, and by understanding the impact of our work, we can get even better outcomes.

Social value provides a way to evaluate services, address inequalities, improve wellbeing outcomes and understand what works well to achieve outcomes of interest and enact change. It allows you to:

- Evaluate the social and environmental impact of the work you do for individuals and to the state
- Inform decision making to create a more impactful and sustainable organisation
- Make the best resource and person-centred decisions possible
- Influence policy makers and stakeholders
- Be consistent with your social purpose
- Demonstrate value for money

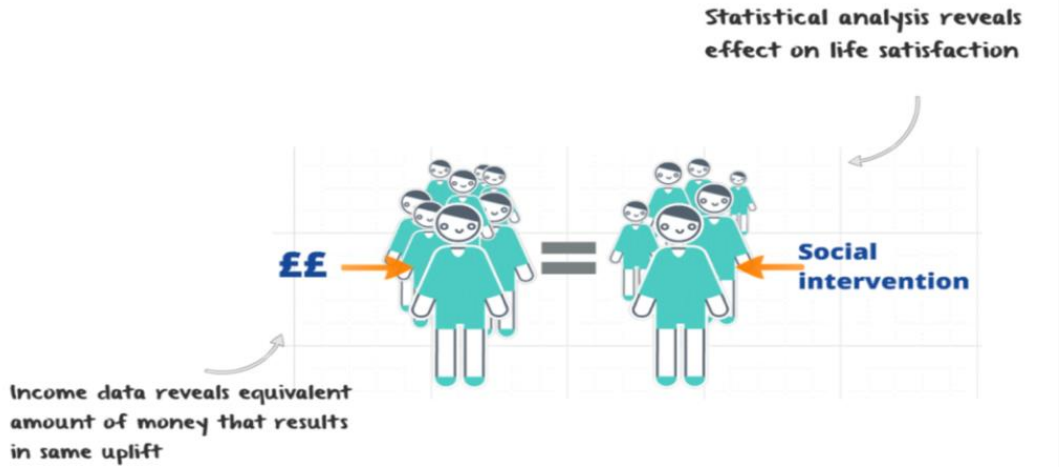
Social value needs to be located in the real experiences of people and communities. When thinking about social value, we can visualise the golden thread from the change people and communities need and want to see for themselves; through what organisations can do about it (how it fits their mission and purpose and ambition), what change or impact is made and, finally, what value does this drive.

UK Social Value Bank and Wellbeing Valuation

Launched in 2014, the UK Social Value Bank (UKSVB) is a HACT resource that offers organisations and businesses a way to understand the social impact of their investment in communities. The UKSVB was developed using the wellbeing valuation approach and features as part of HM Treasury Green Book guidance that sits at the heart of policy evaluation approaches within UK government.

The UKSVB includes over 100 outcomes based on their relationship with life satisfaction. To calculate the outcomes, large national datasets were analysed to identify how people's self-reported wellbeing changes due to different life circumstances. Analysis reveals the impact of these various outcomes on life satisfaction and calculates the amount of money that produces the equivalent impact on life satisfaction. The UKSVB offers a proportionate way to measure social impact and enables insights to be generated around cost: benefits, value for money, investment decisions, service improvements and reporting to stakeholders. It has become the standard method used by the social housing to measure social impact, has been downloaded over 13,000 times, with over 400 organisations attending training and use the model in their business decisions.

The UK Social Value Bank has been created using the Wellbeing Valuation methodology. This approach estimates value by inferring the impact of social outcomes associated with specific projects or interventions on the subjective wellbeing (life satisfaction) of individuals who experience these outcomes. Impact is then converted into a monetary amount by estimating the sum of money which would have an equivalent impact on subjective wellbeing. Wellbeing valuation is therefore a financial measure of how effective a social intervention is by the positive impact it has on an individual's wellbeing.



The UK Social Value Bank also includes exchequer values, which is the indirect, secondary impact of an outcome in net fiscal terms to the government in the form of tax receipts, benefit payments and cost reductions. Cost-savings here are referred to as secondary values because they do not capture the benefits directly to the individual (in terms of their wellbeing) but to society more widely (in the form of 'secondary benefits').

The net exchequer values are calculated using the latest available Government data and respected reports. For example, these could include reports on graffiti removal costs, reduction in costs associated with crime, reduction in GP visits, reduction in unemployment benefits or less frequent use of health services associated with being in a secure job as opposed to being unemployed. Please note, for some outcomes such as 'Apprenticeship', there is a negative impact shown in total social value figure for the exchequer value, as this is something that is primarily government funded.

Adding wellbeing and exchequer values together gives us a combined monetary value reflecting personal wellbeing improvements and net savings to the public purse. It is possible to break this value down further so that we can understand the impact on health, and the resulting savings to the exchequer. Effective practical use of measures and metrics from the UK Social Value Bank requires selecting the most appropriate outcomes, avoiding double counting, applying deadweight.

Deadweight, or what would have happened anyway, is an important part of social impact analysis. To give an accurate picture of social impact a percentage reduction is applied reflecting that a proportion of the outcomes would have happened anyway. The UKSVB applies average deadweight figures from the HCA Additionality Guide. This prevents overclaiming as it does not assume a direct cause and effect relationship between an outcome and an intervention. Using HCA figures saves additional research or a less robust figure being used.

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