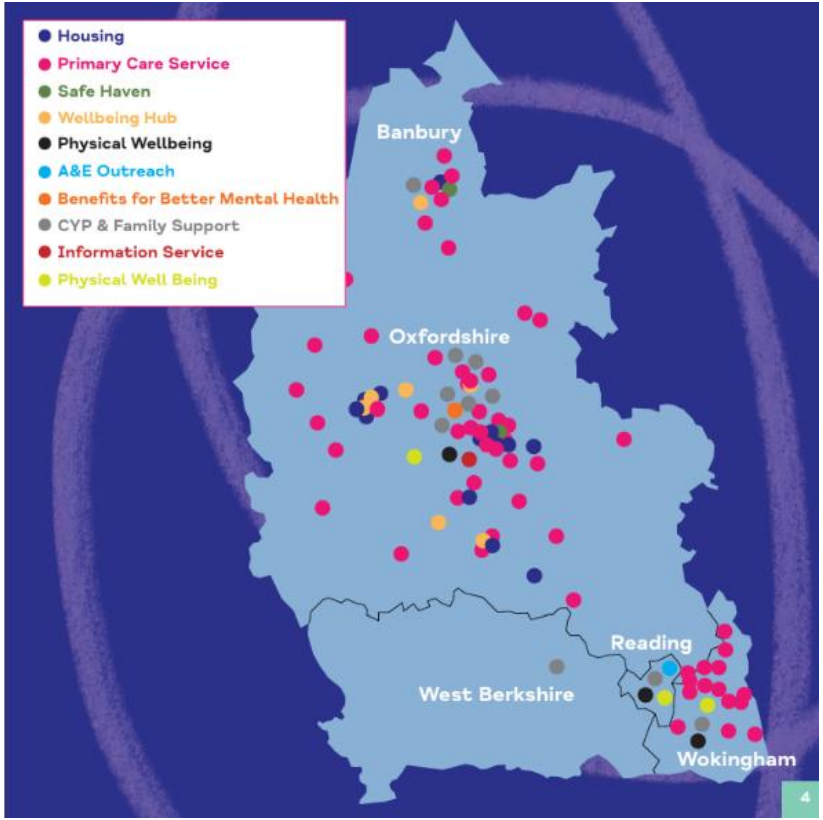

Oxfordshire
mind

Oxfordshire Mind: who we are and what we do

- Local independent mental health charity Oxfordshire & Berkshire
- Mind Federation member
- Established almost 60 years ago
- Service delivery & campaigning
- Housing & Wellbeing including city & district hubs
- Social prescribing

"Local support. Human connection. Real Change."



Social prescribing in Oxfordshire: from pilot to established model

2018 Primary Care Wellbeing pilot begins – City & South West Oxon

2020 PCNs/ARRS enable direct PCN contracts & expansion

2022 Provision for children & young people begins

2023 Mind Federation Supported Self Help service begins

2025 First INT work

PCN = primary care network
ARRS = additional roles reimbursement scheme
INT = integrated neighbourhood team

What does social prescribing look like in practice?

‘a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs. They subsequently connect them to non-clinical support and services within the community by co-producing a social prescription – a non-medical prescription, to improve health and well-being and to strengthen community connections.’

Oxfordshire Mind Primary Care Wellbeing Service

- Support from a professional Oxfordshire Mind worker
- Accessible support embedded with primary care
- Time to understand the whole person
- Agree goals & build self-management
- Practical support and connection to community/statutory services
- Clear boundaries & onward referral where specialist support is needed

Who we support

- Very even representation across age groups
- More women than men
- Ethnicity profile very close to the census data from 2021 for Oxfordshire
- Similar deprivation profile to Oxfordshire when looking at IMD score of service user profiles – small but significant group living in most deprived areas

22% under 30 · 25% aged 60+

Even spread across age groups

13.2% vs 14.4%

Ethnic minority background: service users vs Oxfordshire (2021 census)

4.6% vs 2.6%

In the 30% most deprived areas: service users vs OCC population data

What people bring to us

At initial assessment, we record the presenting needs (up to three) that a client identifies as being important. From April 2023 onwards, the most commonly identified primary needs, in order, were:

- Managing symptoms of anxiety or panic
- Coping with stress
- Improving mood or motivation
- Needing a space to talk
- Support with bereavement and loss
- Living with a physical health issue impacting wellbeing
- Managing symptoms of trauma

How the intervention works and how we complement primary care

- Embedded alongside GP practice teams
- Familiar and accessible route into support
- Non-clinical wellbeing / social prescribing
- Triage, assessment and onward referral
- Reduces pressure on primary care by addressing wider needs
- Builds confidence, knowledge & self-management

“They are real assets to us and your organisation.”

Beyond the presenting problem: wider determinants of health

Mental health is universal, mental health problems rarely exist in isolation

Housing

Income / benefits

Employment

Physical health

Social connection

Relationships

Community

Bereavement

The most impactful social determinants for driving population-level mental health inequalities	The most important factors for assessing the impact of the determinant
Financial situation	Financial insecurity
Housing and household conditions	Safety
Identity-based mistreatment	Violence
Employment	Earning a liveable income
Social connections	Loneliness and social isolation
Access to mental and physical health support	Availability of support

Mental Health Foundation 2025 Delphi Study

Housing and wellbeing

OCC's Housing and Health Needs Assessment identified three different groups of housing which can negatively impact health and wellbeing:

- **Unhealthy and unsafe homes:** cold, damp or in a poor state of repair
- **Unsuitable homes:** where the home environment does not meet the needs of an occupant, e.g. overcrowding, loneliness, unmet care needs.
- **Precarious homes:** financial risks around affordability including risks of homelessness.

"It is good that you can help with everything that is going on- like housing etc."

Employment, income, poverty and wellbeing

- Working age adults in poverty are more likely to report poor health which gets worse with age and low-incomes are linked with higher rates of anxiety (1) .

- The ONS found in 2022 (2) that the prevalence of moderate to severe depressive symptoms was higher among: adults who were economically inactive because of long-term sickness, unpaid carers for 35 or more hours a week, disabled adults, adults in the most deprived areas of England, young adults aged 16 to 29 years and women.

"James was such an incredible support to me during a rough patch in my mental health due to work stress."

Loneliness and social connection

- Loneliness continues to affect many, with 24% of those aged 16+ in Great Britain saying they feel lonely “often, always or some of the time” – 26% said they experience it occasionally .
- Those aged 16–29 were most likely to feel alone (31%) when compared to those aged 70+ (16%).
- The connection between mental health and loneliness is clear. In the same study, 55% of those with moderate to severe depressive symptoms reported feeling lonely, compared to just 16% of those with mild or no symptoms.

'I'm so glad I had someone I could talk to, otherwise I don't talk to anyone. Thank you very much.'

Physical health and wellbeing

- Mental and physical health are deeply connected. According to the APMS, around a third (32.9%) of adults in England with a physical health condition also have a common mental health problem – compared to just 12.6% of those without (1). Despite this, emotional support is rarely offered as routine treatment for people with long-term physical illness.

- In England, people living with severe mental illness are twice as likely to report poor physical health (2), and 5 times more likely to die before the age of 75 compared to those without a diagnosis (3).

"Very pleased and an invaluable service. So many helpful links and signposts that I was not aware of. It has felt like a safe space to talk over my mental health issues and concerns about my future, whilst now living with a Chronic illness."

What difference does it make?

- 78% showed improvement in SWEMWBS score of at least 1 full point
- Average change was an improvement of 4 points
- Consistently high levels of satisfaction (% choosing “agree” or “strongly agree”)
  - Did you get the help you needed to understand your mental health? **91%**
  - Did you get the help that mattered to you? **91%**
  - Did you have confidence and trust in staff working with you? **95%**
  - Were your concerns taken seriously? **97%**

Who would people ask for help in future?

- At the end of a client's support, we ask them where they would seek support if they had a similar issue in future.
- 71% of those who responded since 1st April 2023 said they would return to a Wellbeing Worker at the practice.

"The service has really helped me to not feel so overwhelmed by my problems and to help break down my thought processes. This has helped to make them more manageable. I do feel in a completely different place. In the future, if I needed more support, I would contact my GP initially and then ask to be referred to the WB service again"

- People report feeling better equipped to manage future difficulties
- Practical tools support longer term self-management

Social prescribing as prevention and early intervention

- Accessible support can reach people earlier
- Provides help before needs escalate
- Builds self-management and resilience
- Can engage people who may not otherwise access mental health services
- Connects people to the right support at the right time

“I would never have accessed a ‘mental health service’… Seeing someone in my GP practice… was just what I needed.”

What have we learned? Challenges and limitations

- Sustainability depends on funding and commissioning
- Provision has changed with local demand… and PCN finances
- Referral pathways and capacity matter
- Clear boundaries and onward routes are important
- Provision for children & young people is particularly valued where alternatives are limited
- Consistency of access remains an important consideration

From individual support to neighbourhood health

- Learning from primary care wellbeing project & social prescribing can inform neighbourhood working plans
- Integrated Neighbourhood Teams (INT) work from 2025: community-based support and home visits
- Focus on people with complex/wider needs
- Connecting people with local community resources
- Extending support beyond the GP practice

Opportunities for Oxfordshire

- Building on an established, effective, local model
- Strengthen prevention & early intervention
- Embed wider determinants of health into wellbeing support
- Connect primary care, neighbourhood and community provision – with mental health & wellbeing throughout
- Improve equity of access county-wide
- Consider prevention across the life course

What could happen next?

How do we build on what is already working and create the conditions for it to work consistently across Oxfordshire?

- Consistent equitable access
- Sustainable commissioning & funding
- Opportunities for joined up primary / community / neighbourhood working
- Focus on prevention & early intervention

Informed by impact & service user experience data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