August 2018

Social impact of the Arfon Community Link project. Social Return on Investment (SROI) Forecast report June 2016-September 2018

"Can you imagine what it's like not to speak to anybody for a whole month" (individual)

MANTELL GWYNEDD
Yn cefnogi grwpiau gwirfoddol a chymunedol
Supporting voluntary and community groups

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Contents

Executive Summary

Community Link is a service based in Arfon, Gwynedd, using a social prescribing model, which offers an alternative for individuals with social and emotional needs. This report considers the data from October 2016 and will forecast until September 2018 to get a better understanding of the impact created by this service. The project was analysed using the Social Return on Investment (SROI) framework to understand the total value created for individuals who were referred to the service as someone who perhaps was dependent on statutory service but needed alternative support to medicine. Where possible, existing data has been used to calculate the value of the social prescribing service, and in other circumstances careful estimations and modelling of the potential impacts has been included to provide a conservative appraisal of the programme. The results demonstrate that significant value is created through the Community Link project by utilising services offered by the third sector.

The result of £5.23:1 indicates that for each £1 of value invested, £5.23 of value is created.

There is a growing need for an alternative to support the growing pressure on statutory services. There are vast amounts of services available locally, and the Social Prescription model offers the missing link to ensure that those who are most isolated in communities are able to access these services and reduce the pressure on statutory services.

Outcomes experienced by clients include **improved mental and physical health, and reduced loneliness and isolation**. For many, this service provided them with the reassurance that there was support available for them within their community, and by having the time to communicate their concerns with the Community Link Officer they had an increased awareness of services available and was able to feel satisfaction that they had something to look forward to.

Acknowledgements

This report would not be possible without involving key stakeholders who help us to understand what changes and establish the impact. For those that received support from the service, their involvement was key and we're extremely grateful to them for feeding back on their experiences and their willingness to help us understand what happens. A huge thank you to Rhian who is clearly passionate about the work, and in many cases, had gone above and beyond to help the individuals. Also, a big thank you to all staff at Mantell Gwynedd for their involvement.

Diolch yn fawr / Thank you

Eleri Lloyd

1.0 Introduction

This forecast report will analyse the value of the Community Link project in Arfon provided by Mantell Gwynedd established in June 2016. The impact of this service on individuals will be considered, but also the value to other statutory services, especially the Health Board.

Through engaging with both individuals receiving the service, family members, peer mentors and the organisations and examining information and data was available, appropriate estimations have been made supported by secondary evidence.

This report will analyse the findings from this pilot using the Social Return on Investment (SROI) framework to complete an evaluation report up to September 2018 but will forecast the anticipated impact created by this service to individuals.

1.2 Purpose and scope

This is a Social Return on Investment (SROI) forecast to measure the social value of the role of the Community Link project in Arfon. This report looks specifically on the outcomes and their value for Individuals who are referred to the project who suffer from various social needs such as loneliness and isolation.

This report was prepared to review and ascertain the following:

- The views of the key beneficiaries involved in the project, that being the individuals referred.
- The outcomes experienced by all material stakeholders, but most importantly the Individuals.
- To give a value to the service and to answer the question does Community Link provide good value for money.

- To see what changes to the service can be introduced to provide more outcomes and further value to beneficiaries.
- To recognise the value of this social prescribing model.

1.3 Audience

This report has been prepared for both internal and external audiences. These include:

- **Funders** –This project was funded initially through the Intermediate Care Fund (ICF) for 9 months which included all set up costs, and was then funded through the local GP Cluster group. The funders will need to understand the value that is created from their investment, and how the project has had an impact on their service.
- **Internal Management** – By measuring the social value of this service and understanding what the outcomes are for individuals decisions can be made based on this information to manage and plan services.
- **Policy and Decision Makers** –With new legislation in Wales there is an increasing need to understand what is most valuable to service users, and how services prevent people from needing statutory care. Although a higher level of rigour would be needed to have an impact on policy and further data, this report will help to demonstrate the impact of services being co-produced.
- **Individuals** – To understand and communicate the value of the service to those who matter the most, the individuals receiving the service.

2. Background & Context

Key Organisation(s)

Mantell Gwynedd operates as a charity (Charity Number 1068851) and company limited by guarantee (Company Number 3420271), and as the County Voluntary Council for Gwynedd their role is to promote and support the multiple needs of the third sector in Gwynedd, as stated by the organisation;

'promote any charitable purpose for the benefit of residents in Gwynedd and especially through assisting and supporting charitable purposes and the work of voluntary organisations in the area'.[1]

Project Outline

Community Link (social prescription model) was established as a pilot in June 2016. It will allow primary care services to be able to refer individuals with social, emotional and practical needs to a range of locally based services.

The project works closely with GPs and clinical staff to explore alternative ways of helping individuals within the community, particularly those who are visiting health care professionals more often than average with non-clinical needs. Through the Community Link Officer at Mantell Gwynedd, the role of social prescription is then to use knowledge of the activities and services offered by the local third sector to identify opportunities for people to engage in activities that create positive impacts in the lives of people and reduce their demand on statutory services such as the NHS and Social Services.

[1] Mantell Gwynedd www.mantellgwynedd.com

Through engaging with the individuals and gathering data, appropriate estimations have been made based on secondary evidence to arrive at an assessment of the value likely to be created by Mantell Gwynedd.

Social prescription is a new model that is developing in different areas of the UK with a focus on offering alternative solutions to individuals emotional and social needs. One of the most recognised models is seen in Rotherham and the report prepared by Sheffield Hallam University[2] on this model describes social prescribing as,

"Solutions for improving the health and well-being of people from marginalised and disadvantaged groups that place greater emphasis on preventative interventions have become increasingly common in public policy. Social prescribing commissions services that will prevent worsening health for people with existing LTCs [Long-term conditions] and reduce costly interventions in specialist care." (p.1)

The aim of the project is to reduce demand on statutory services by providing a long-term solution for individuals that has a positive impact on their lives. The Community Link Officer works closely with local GPs and clinical staff to try and embed this service into part of their services to individuals, offering an alternative to medical treatment. However, as the project developed referrals were also received by Social Services and the Community Mental Health team (Health and Social Care Unit, Gwynedd Council) as well as others. A full list can be seen in table 6 later on in this report.

When a referral is made, the individual will have an initial meeting with the Community Link Officer, to identify their needs, allowing them to be central to the discussion of looking at

[2] Dayson, D. Bashir, N. Pearson, S. (2013). From dependence to independence: emerging lessons from the Rotherham Social Prescribing Pilot. Summary Report. Sheffield Hallam University.

solutions to their needs. Meetings with the Officer will be restricted to no more than 5 sessions and referrals will be made to other third sector organisations where appropriate. By having the support at the beginning to assist people to become more involved in various activities, the Community Link Officer is able to "hold their hand" to take those first steps that can start to integrate them in to the community and reduce dependency on services. The Process can be seen on page 12.

The service is available to anyone who is 18+ who have social or emotional needs and perhaps feel isolated within a community. Many of those referred are living with various mental and physical health conditions which has created barriers for them previously.

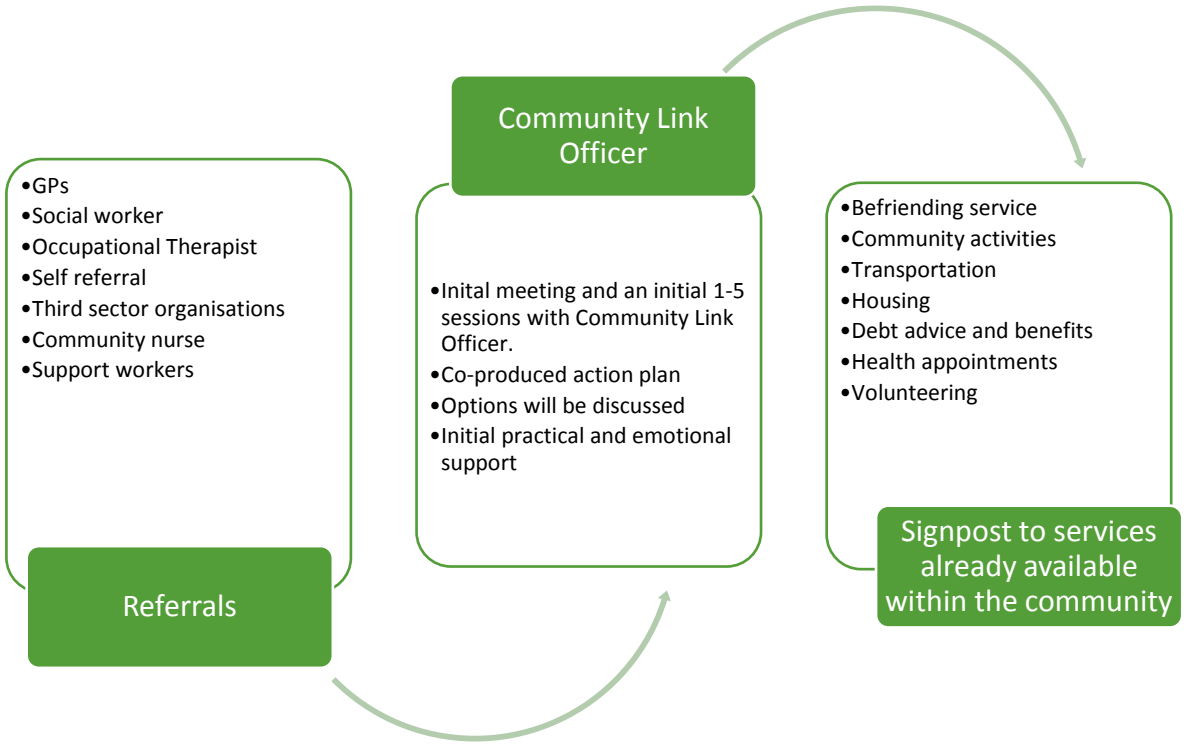
By January 2017 there were 24 referrals made to the service mainly from GPs but with some referrals coming from Social Services, Occupational Therapists and others with a target of 50 referrals by the end of March 2017. By the end of June 2017, 120 referrals had been made to the service which exceeded the target, and goes some way to demonstrate the demand from statutory services to offer an alternative to some individuals / patients. By July 2018 there are 366 referrals with a forecasted 394 receiving support by the service by the end of September 2018. The needs of the individuals varied with some needing more intense support and others requiring a subsequent referral or signposting only. For each other referral, an action plan is created in partnership with the Officer, helping to focus the search for alternative options available. For some of these services, the Community Link Officer will work with clients to fill out the necessary forms or will directly make a referral, for others it will be providing the information only. Some examples of available services include;

- Education Programs for Patients – health and wellbeing
- Mind

- Carers Outreach/ Cynnal Gofalwyr
- Citizens Advice
- Employability support – such as OPUS project, Cyfle and Pace
- Exercise Referral
- Walking groups
- Library services
- Deafblind Cymru
- Wildlife Trust
- Canolfan Lon Abaty
- Specialist groups such as Action for Hearing, Stroke Association, Alzheimer's
- Red Cross
- Age Cymru Gwynedd & Môn
- Canllaw – housing improvements
- Shelter
- Hafal Clic
- Cancer support Mcmillan /Tenevous
- Arfon Falls Prevention
- Telecare
- Coleg Menai
- Samaritans
- Screening for life Wales
- Community based activities
- Royal British Legion /Ssafa

- Ffrindia' Befriending scheme (Came to an end in March 2017)
- RVS
- Lunch clubs
- Men's Sheds
- Housing Associations
- Local training opportunities such as art or language courses
- Volunteering Opportunities
- Community Transport

Process of service



In some cases, the Community Link Officer will attend the first meetings with the individual or will arrange transport that might have been a barrier to engagement previously. Attending the first session or walking in to a new venue can be a barrier for many individuals, and therefore taking those first steps with them can be important to achieve a positive change.

This service is currently available in the Arfon area which include the city of Bangor, Caernarfon area and down to Dyffryn Nantlle. A full list of towns and referrals where referrals

were made are available on page 36. If this project proves to be successful in reducing demand on services, then this service could be rolled out to be available throughout Gwynedd.

As part of this project, it was emphasised that continuous monitoring should be conducted using the Social Return on Investment (SROI) framework with Social Value Cymru being commissioned to do the work and an evaluation and forecast report being available in June 2017, and update report in December 2017 and now a full evaluation and forecast report until September 2018.

Identifying the need and strategic context

There is a increasing pressure on statutory services due to public spending challanges, and this creates the need to consider alternative ways of offering services to be seen as a priority. The social prescribing model has already been adopted in some areas such as Bristol and Rotherham. In their paper 'Developing a Social Prescribing approach for Bristol'[3], the authors discuss how a response was needed to deal with the 'crisis' on services,

"GP surgeries are facing an increase in number of presentees. In reality GPs are not necessarily equipped to handle all the social and psychological burdens that individuals present with. The traditional GP model of service delivery is changing." (p.11)

These are challenges that are being recognised in Wales also, and plans and strategies are already being developed as well as the new legislation in response to the predicted changes in National population characteristics. The Office for National Statistics predicts that the

[3] Gray, C. (2013). Developing a Social Prescribing approach for Bristol. Bristol Health and Wellbeing Board.

number of the population that is over 65 will increase 44% over the next 25 years, [4] which brings its own challenges for Health and Social Care providers.

In response to the new legislation in Wales, a Population Needs assessment[5] has been conducted that allows a detailed assessment of needs by local area. Public Service Boards are established to ensure that all services work together to respond to these needs locally and create a better future in Wales[6]. The data available demonstrates that 27% of people in Gwynedd are economically inactive, with this rate higher in Bangor at 37%. Fuel Poverty in Gwynedd is 21% of households compared to the average of 14% in Wales. The Suicide rate in Gwynedd is 14.7 per 100,000 which is higher than the Wales average of Wales at 12.2. These figures allow organisations to identify the social, physical and emotional needs are in their local areas to plan their services accordingly.

On the 23rd May 2017, Vaughan Gething, The Cabinet Secretary for Health and Social Services introduced agenda item 8 in the Plenary in the Senedd which was a debate on Social Prescribing. He discussed the growing evidence of people attending GP for social issues and referred to the King's Fund[7] definition of Social Prescribing as,

"'a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services.'"[8]

This debate clearly demonstrated the need for such early intervention schemes and it was also stressed that there is a need for such service for younger people as well as for the elderly. Dai Lloyd AM, himself a GP, also gave a personal definition of social prescribing,

[4] Welsh Government – National Population projections (2015). http://gov.wales/statistics-and-research/national-population-projections/?lang=en
[5] Gwynedd and Anglesey Well-being consultations (2016). https://gwyneddandmonwell-being.org/
[6] Welsh Government (2016) http://gov.wales/topics/improvingservices/public-services-boards/?lang=en
[7] https://www.kingsfund.org.uk/topics/primary-and-community-care/social-prescribing
[8] Welsh Government (2017) http://senedd.assembly.wales/ieListDocuments.aspx?MId=4292

"That's what my understanding is, basically, of social prescribing—that GPs and nurses in the community can refer people to projects that tackle their illness, looking at the bigger picture of their health in its entirety, referring people, therefore, to the voluntary sector, most often, such as arts activities, volunteering, gardening, cooking, healthy eating advice and a wide range of sporting activities, such as walking."[9]

Much has happened since this debate to map evidence around social prescriping. Public Health Wales Primary Care Hub was established to be "tasked with supporting and emerging interest in social prescribing in Wales." This includes the development of the All Wales Social Prescribing Reasearch Network tasked to identify what are the research priorities for the development of social prescribing models in Wales.

An increasing need to support those with mental health issues is recognised and the Welsh Government has prepared a 'Together for Mental Health Delivery Plan 2016-2019'[10] as a response to this need. A number of the actions in this Plan is a response to the Social Service and Well-being (Wales) Act 2014[11] which transforms the way Social Services are delivered. This also is a response to the Well-being of Future Generations (Wales) Act 2015[12] which aims to;

- Think more about the long-term
- Work better with people and communities and each other
- Look to prevent problems and take a more joined-up approach.

[9] Welsh Government (2017) http://senedd.assembly.wales/ieListDocuments.aspx?MId=4292
[10] Welsh Government (2016). http://gov.wales/docs/dhss/publications/161010deliveryen.pdf
[11] Welsh Government (2016) http://gov.wales/topics/health/socialcare/act/?lang=en
[12] Welsh Government (2016) http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en

Social Prescription, although not a recent concept, is a way to respond to these new pieces of legislation to consider doing things differently and offering alternative ways to create long-term solutions.

One of the fundamental principles of the Social Service and Well-being (Wales) Act 2014 is prevention and early intervention. Social Prescribing allows primary care providers to refer individuals to services within the community that can help improve emotional and physical needs without having to rely on statutory services. By identifying early on those with needs, prevention from deterioration to more serious health needs can be addressed. These changes can take months, possibly even years to realise, which is important when analysing a pilot project in operation for only 12-18 months. The report on the Rotherham Social Prescribing Model[13] noted that changes were identified after 18-24 months. These outcomes included;

- Improved health and quality of life
- Increased patient satisfaction
- Fewer primary care consultations
- Reductions in the number of hospital admissions
- A decrease in the use of wider hospital resources.

One of the emotional needs most cited by GPs and in research as a reason for using health services when there is no clinical need is the loneliness of the patient. Although an emotional state, loneliness has been identified as having high risks of causing many physical and mental

[13] Dayson, D. Bashir, N. (2014). The social and economic impact of the Rotherham Social Prescribing Pilot: Main Evaluation Report. Sheffield Hallam University.

illnesses. Table 1 identifies some of those risks and how this can have implications in later life taking from the Ffrindia' befriending SROI report[14].

Table 1 – Risk Factors and Implications of Loneliness in Later Life

Personal risk factors		Wider societal risk factors
Poor health or sensory loss		Lack of public transport
Reduced mobility		Inappropriate physical environment (i.e. lack of public toilets, non-dementia aware environments)
Bereavement		Unsuitable housing
Retirement		Fear of crime
Becoming a carer		Technological changes
Potential implications of chronic loneliness		
Physical health	Exceeds impact on mortality of factors such as obesity – similar effects as smoking 15 cigarettes a day (Holt-Lunstad, 2010)	
	Increases the risk of high blood pressure (Hawkley *et al.* 2010)	
	Increased risk of disability (Lund *et al.* 2010)	
Mental health	Greater chance of cognitive decline (James *et al.* 2011)	
	64% increased likelihood of developing clinical dementia (Holwerda *et al.* 2012)	
	Increased chance of depression (Cacioppo *et al.* 2006; Green *et al.* 1992)	
	Increased likelihood of suicide in later life (O'Connell *et al.* 2004)	
Maintaining independence	Increased number of visits to GP, higher use of medication, greater incidence of falls & increased factors for long term care (Cohen, 2006)	
	Early entry into residential/nursing care (Russell *et al.* 1997)	
	Increased use of accident & emergency services (independent on chronic illness) (Geller, Janson, McGovern & Valdini, 1999)	
Adapted from Campaign to End Loneliness, 2016		

[14] Richards, A. (2016). Ffrindia' Social Return on Investment Report – The Value of Friendship.

This analysis will consider how the social prescribing model can respond to the needs of the new legislation in Wales, the needs of local residents based on the Population Needs Assessment and if it can reduce some of the pressure on statutory services, but most importantly create a positive change in the lives of Arfon residents.

2.0 Methodology- Social Return on Investment (SROI)

By explicitly asking those stakeholders with the greatest experience of an activity, SROI can quantify and ultimately monetise impacts so they can be compared to the costs of producing them. This does not mean that SROI can generate an 'actual' value of changes, but by using monetisation of value from a range of sources it is able to provide an evaluation of projects that changes the way value is accounted for – one that takes into account economic, social and environmental impacts. Social Value UK (2014) states;

'SROI seeks to include the values of people that are often excluded from markets in the same terms as used in markets, that is money, in order to give people a voice in resource allocation decisions'

Based on seven principles, SROI explicitly uses the experiences of those that have, or will experience changes in their lives as the basis for evaluative or forecasted analysis respectively.

Taking a more holistic approach to impact measurement means that positive, negative, intended and unintended changes can be accounted for on a constructed Value Map – and ultimately when these are compared to the relative costs of their creation, the SROI is identified. The formula used to calculate the final SROI is highlighted below;

$$\text{SROI} = \frac{\text{Net present value of benefits}}{\text{Value of inputs}}$$

For example, a result of 4.50:1 indicates that for each £1 of value invested, £4.50 of social value is created.

However, SROI is much more than a number. SROI is a story of change, incorporating social, environmental and economic costs and benefits, requiring both quantitative and qualitative evidence.

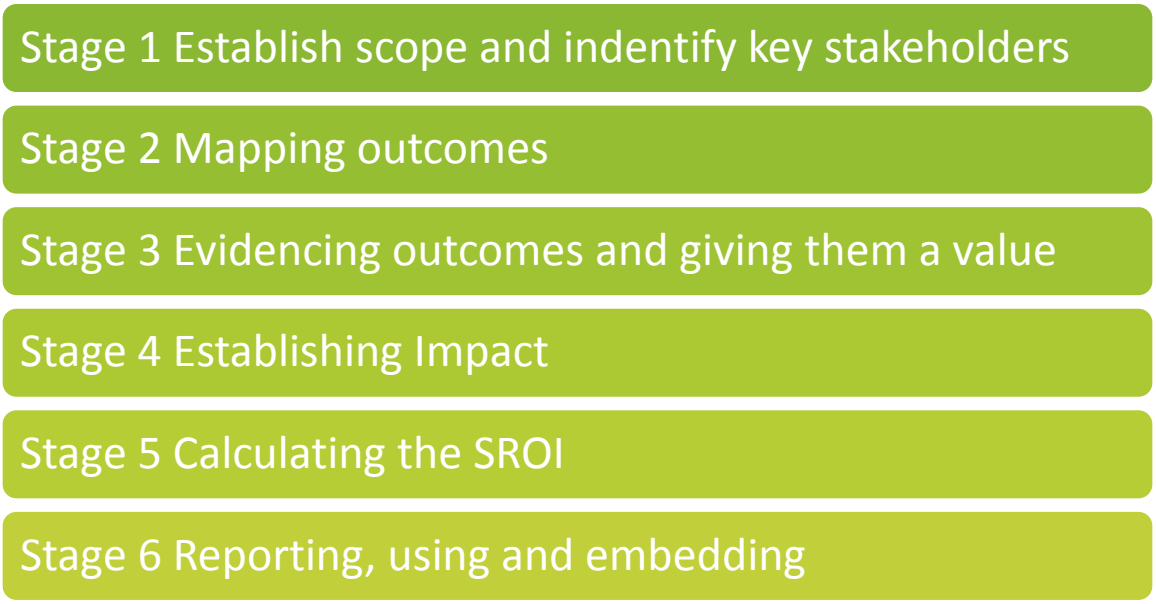
There are two types of SROI reports, evaluative and forecast. This report is a forecast SROI report as we are measuring results up to September 2018. At the time of analysis, the project had been operating 25 months and as such existing data was used to support the analysis, but as there was still 2-months until completion the analysis forecast the value created for the remaining individuals on the programme. SROI does not provide a rigid method of measuring social value, rather it is based on seven principles and these underpin how SROI should be applied. The use of principles is intended to provide consistency, yet also allow flexibility to recognise and incorporate varied experiences of different people, and these are highlighted in figure 2.

Figure 2 - Social Return on Investment Principles [15]

These principles overarch everything that we do during the analysis, and is also a good framework for any organisation to adhere to. As well as the principles, there are six stages to conducting an SROI analysis as seen in figure 3.

[15] www.socialvalueuk.org

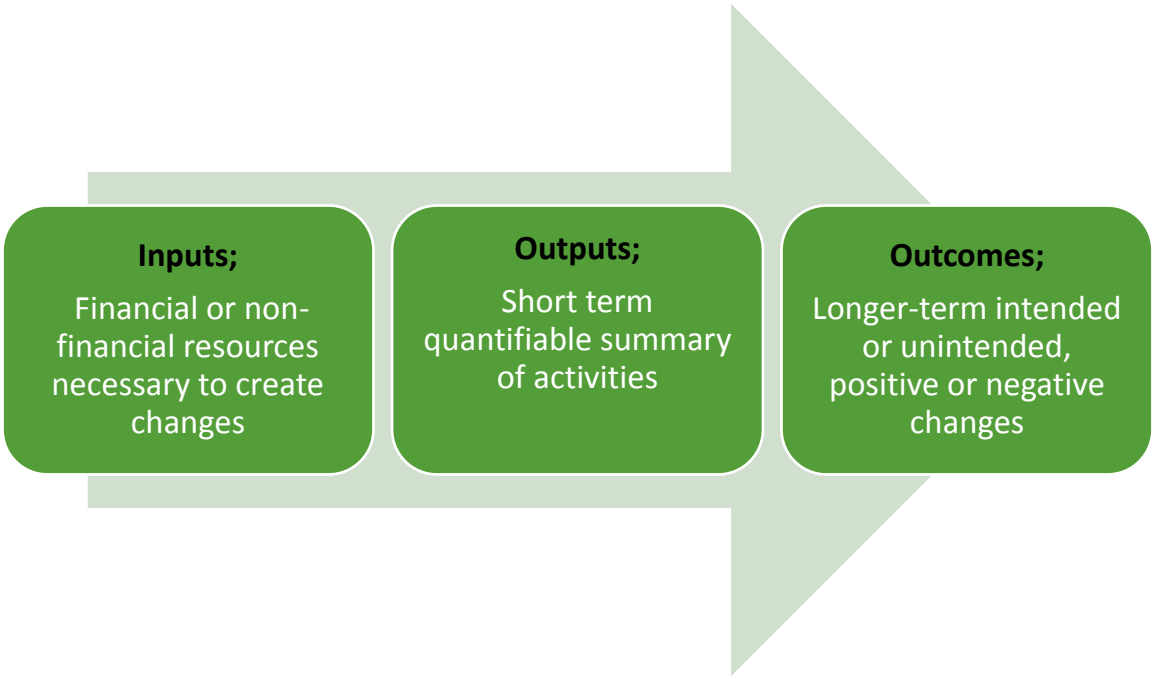
Figure 3 - Social Return on Investment Stages[16]



Whilst different analyses will apply varied techniques to capture data, adherence to these principles of good practice ensures that the *how* of social impact measurement remains central. As a result, for each material stakeholder, chains of change are created on the Value Map (appendix 3) that articulates the transformation process from necessary inputs, through immediate outputs to ultimate measurable outcomes. Figure 4 highlights the fundamental elements of the chain of change, albeit a simplistic visualisation when accounting for complex changes.

[16] www.socialvalueuk.org

Figure 4 – Chain of Change



Inputs can be financial or non-financial resources. For example, whilst a project may require necessary finances, it will also be dependent upon the time, expertise and other intangible resources of people to ensure its success.

Outputs are often the things that are measured as a result of activities, yet importantly these do not indicate to the success or failure of activities. Take for example, a course providing advice and skills to enable people to secure employment that only measures the output of the number of attendees of each course; this does not indicate the relative success or failure of the course on the important outcome of people securing employment. Regardless of the activity, only by measuring outcomes can we be confident that an intervention is working, and this is the explicit focus of SROI.

The key distinction of SROI allows identified material outcomes to be monetised, after which accepted accounting principles are applied that progress the analysis towards understanding the impacts of activities. In accordance with the principle not to over-claim, key questions must be asked for each outcome to understand the value of a change that is a result of a particular intervention, those of; How long will the change last (duration)? How likely is it that this change

could have occurred without the intervention (deadweight)? Who else contributed to their creation (attribution)? Have these activities displaced outcomes that would have occurred elsewhere (displacement)? And how does the value of the change that is as a result of the intervention reduce in future years (drop-off)?

In summary, SROI is able to articulate an understanding of holistic value created and destroyed as a result of activities. By understanding the value of outcomes we are in a stronger position to manage them as we have a greater understanding of their relative importance and can target strategy and resources more effectively. Monetisation of outcomes is not an attempt to place a price on everything; rather it is designed to not only allow for the meaningful measurement of impacts, but also importantly for their subsequent management. This is of particular relevance for third sector organisations, as adherence to a social mission places a moral duty on decision-makers to maximise their social returns. Effectively, SROI can bridge the accountability gap that often occurs between those with decision-making powers, and those that decisions are intended to target.

3.0 Stakeholder Engagement & Scope of the Analysis

Including stakeholders is the fundamental requirement of SROI. Without the involvement of key stakeholders, there is no validity in the results – only through active engagement can we understand actual or forecasted changes in their lives. Only then can SROI value those that matter most.

To understand what is important for an analysis, the concept of materiality is employed. This concept is also used in conventional accounting, and means that SROI focuses on the most important stakeholders, and their most important outcomes, based on the concepts of

relevance and significance (see figure 4). The former identifies if an outcome is important to stakeholders, and the latter identifies the relative value of changes. Initially, for the evaluation of Arfon Social Prescription Model, a range of stakeholders were identified as either having an affecting, or being effected by the project – table 2 highlights each stakeholder, identifying if they were considered material or not for inclusion within the SROI analysis.

Figure 4 – Materiality Principle

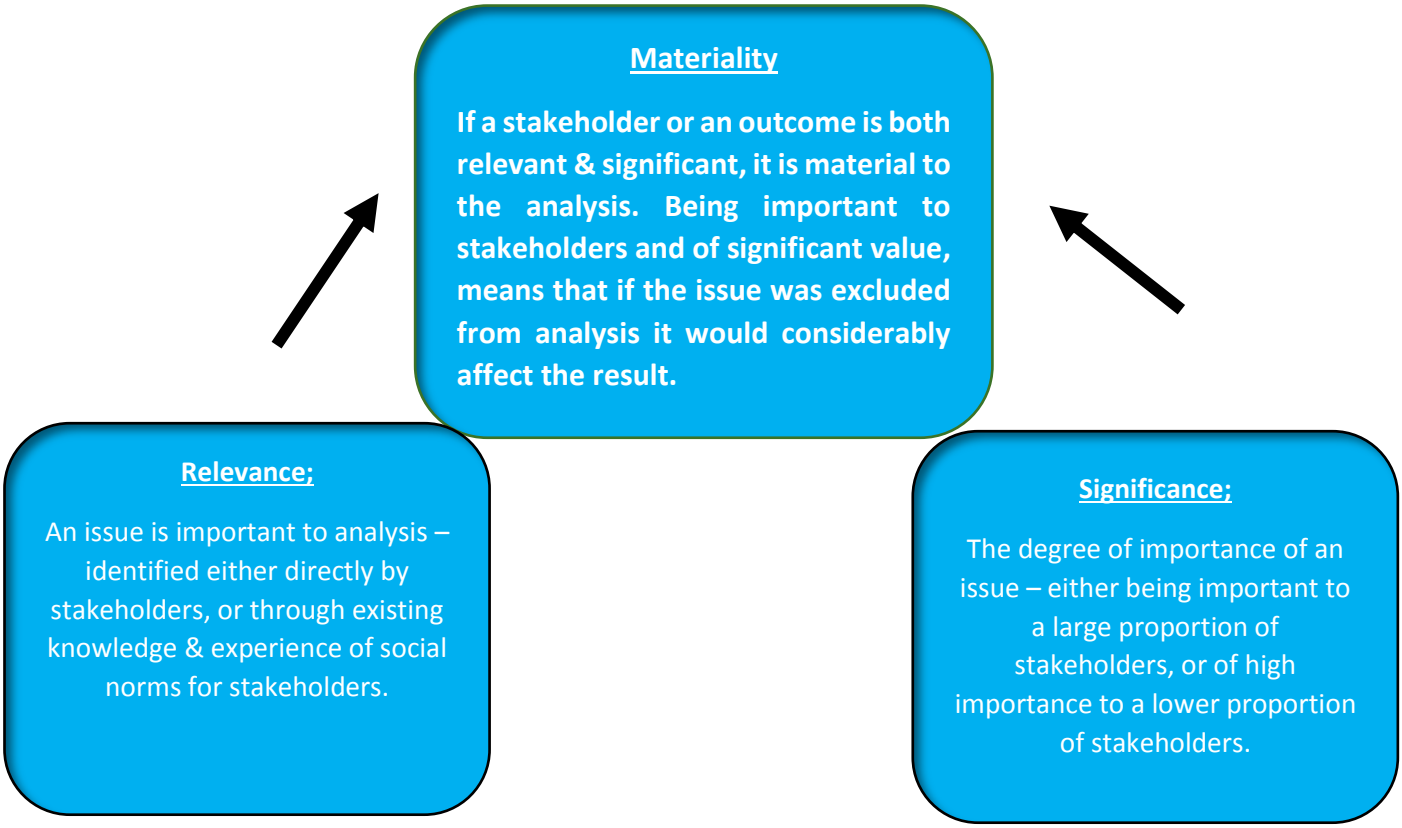


Table 2 – Stakeholder List & Materiality

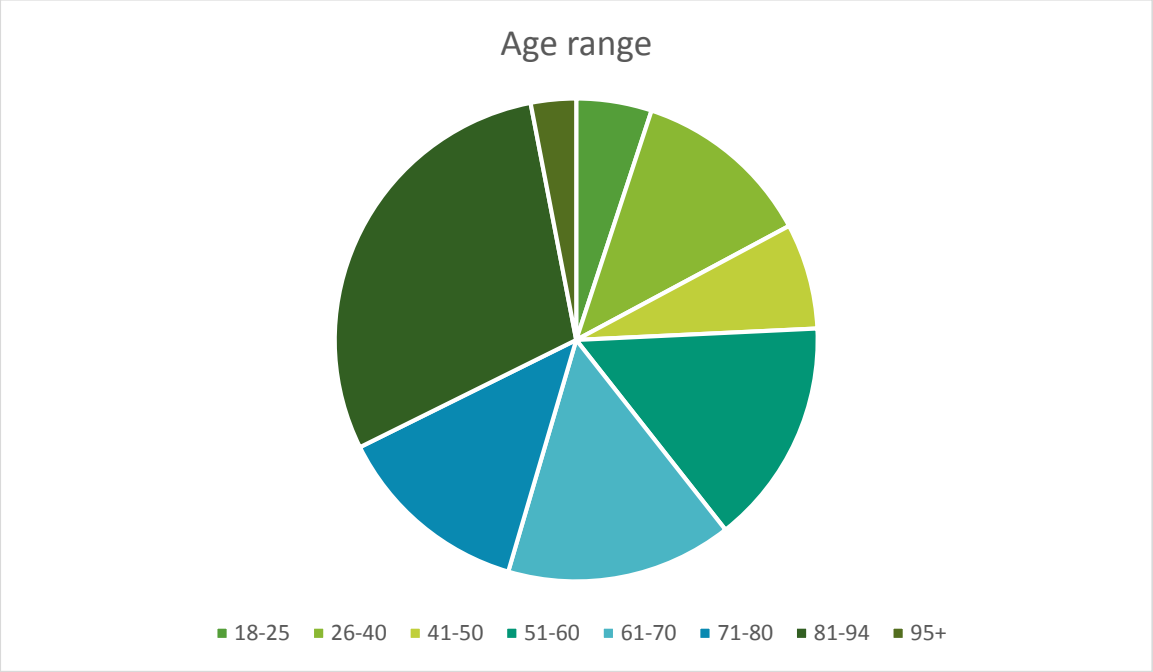
Stakeholder	Material stakeholder?	Explanation
Individuals	Yes	As key beneficiaries of the service these are the most important stakeholders and some changes experienced will be both relevant and significant.
Family members	No	Although the changes to the individuals potentially have an impact on other family members, unfortunately we were not able to engage with them for this analysis.
Mantell Gwynedd	Yes	The involvement of Mantell Gwynedd is essential for the creation of any changes. Therefore, financial resources and the inputs from key members of staff must be included. However, changes experienced by the organisation are not included as they are not relevant to the project.
NHS – GP surgeries	Yes	As a key referral agent, partnership working with them is essential towards the success of the service. Any impact and changes for the individuals is likely to have an impact on their demand of such services also.
Social services	No	As a key referral agent, partnership working with them is essential towards the success of the service. Any impact and changes for the individuals is likely to have an impact on their demand. However, for this short-term pilot, not enough data is available to identify the value to them but will be considered in the longer term.

Other Third Sector Organisations	No	Although the changes to them will be relevant as without them this service wouldn't be possible, their changes will not be significant. However, they are recognised in the attribution of outcomes, and future evaluation could include them to see what impact the project has on their referral rates.

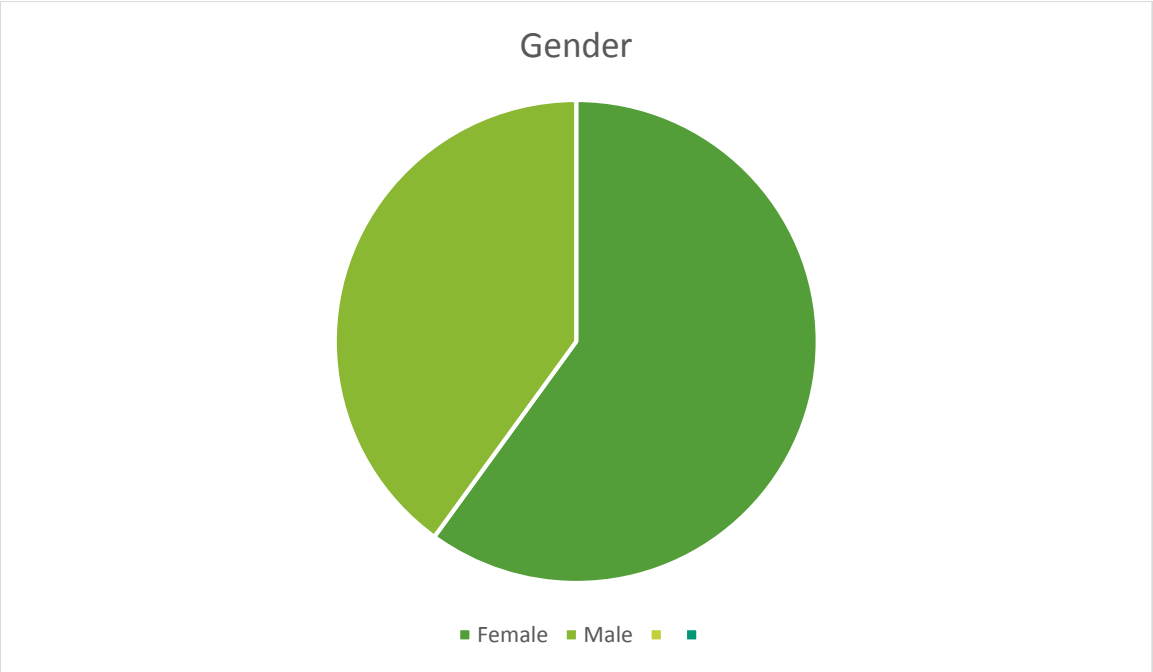
Potential subgroups of stakeholders

It's important to recognise that not not all individuals are the same. Understanding if different characteristics has an impact on the data can help us to manage and inform decision making. Consideration is therefore given to the three different characteristics below which is age, gender and whether they live in a rural or urban setting. The diagrams below demonstrates the groups represented in this project.

Age data



Gender data



Area data – Caernarfon and Bangor are more urban areas, where the others are more rural.

Ardal	Niferoedd
Abergwyngregyn	1
Bangor	104
Bethel	4
Bethesda	21
Botnewydd	5
Brynrefail	6
Caeathro	1
Caernarfon	79
Carmel	1

Clwt y Bont	2
Cricieth	1
Deiniolen	14
Dinas	1
Felinheli	10
Fron	6
Groeslon	16
Llanberis	10
Llandegfan	2
Llandwrog	7
Penygroes	16
Pontllyfni	2
Talysarn	4
Treborth	1
Trefor	1
Tregarth	17
Waunfawr	3
Rachub	2
Rhosgadfan	3
Rhiwlas	3

The target was set for referrals to the project as 50 over the 9-month initial pilot period. By 17th March 2017, there had been 58 referrals and by the end of June 2017 there were 120 referrals made. By September 2018 it is forecasted that 394 referrals will be made to the service. Although the project originally was only meant to take referrals from GPs, referrals were made also by the Mental Health team and Social Services, all identifying a need for this service. A table of all referral sources and percentages is shown in table 6 on page 36.

Involving stakeholders right from the beginning is essential to influence any paperwork and monitoring processes to understand what possible changes there will be. As this was a new project, monitoring systems were developed using secondary research on the impact of other similar projects. Members of Mantell Gwynedd visited the Rotherham Social Prescribing Pilot, and identified their eight measurements which included Feeling Positive, Lifestyle, Looking after yourself, Managing Symptoms, Work, Volunteering and other activities, Money, Where you live and Family and friends. The paperwork created for this pilot had similar measures considering finance and housing, mental and physical health, self-esteem, loneliness and employment and skills. The paperwork can be seen in Appendix 1.

An initial review was conducted after 2-3-month period, which is a short amount of time to identify many significant change, but this was due to the timescale of the project itself. It was also possible for the officer to ask individuals where they hope to be in few months' time to forecast of any changes. Further qualitative interviews took place in December 2017 and June 2018. These individuals had received support from the Community Link Officer a few months prior interview and could therefore provide us some insights into any changes.

Having identified the material stakeholders for analysis, table 3 highlights the size of the populations, the sample size engaged with and the method of engagement.

An initial conversation was had with the Community Link Officer and the Project Manger to understand the scope and the potential list of stakeholders. As well as monitoring through the paperwork, ten interviews were also held with individuals who had been referred early on to see if there were changes already happening.

Unlike quantitative methods, qualitative interviewing does not have a statistical method for identifying the relevant number of interviews that must be conducted. Rather, it is important to conduct sufficient number until a point of saturation is reached – this is the stage at which no new information is being revealed

Table 3 – Stakeholder Engagement

Stakeholder	Population size	Method of engagement
Individuals	394	10 x face to face interviews 100 x Analysed a sample of data following second review.
Mantell Gwynedd	1	Regular meetings with Community Link Officer and Project Manager
NHS	1	Direct contact with NHS departments was not possible for this analysis. However, a discussion was conducted with one of the referral GPs. The information collected from those directly involved in the service and data from Mantell Gwynedd provided sufficient information to arrive at reasonable estimations of impact.

4.0 Project Inputs

This section of the report describes the necessary inputs from multiple stakeholders. Some inputs are financial, whereas others are not – yet where possible inputs are monetised.

Individuals

This service is free to those that receive it but some non-financial inputs are also necessary to ensure any changes. Their willingness to work with the Community Link Officer and take action to integrate into the community and take part in the activities is essential to ensure any outcomes. A high number of the individuals had likely been isolated for some time and therefore this might take a lot of time and effort for them to make, but is required to ensure any benefits.

Mantell Gwynedd

The financial input is managed by Mantell Gwynedd. A financial input of £55,773 was provided for the 9-month pilot by the Intermediate Care Fund 2016-17 which is managed by the North Wales Social Care and Well-being Services Improvement Collaborative. This paid for the salary of a full-time Community Link Officer, administration support, management and resources. This also included the start-up costs of recruiting and marketing the service. Following this 9-month pilot the ICF fund was no longer able to support the programme, and therefore the Arfon Cluster team gave a financial input of £82,000 to continue the programme until September 2018.

The skills of the Community Link Officer to work with individuals in an empathetic manner and being able to identify their needs and match that with locally available options within the

community and the third sector is essential to the success of the project. The ability to establish a good partnership and work closely with the GP surgeries and Social Services is also important to ensure the success of this project.

Initial meetings will be done by the Community Link Officer, and the number of sessions with individuals will vary from 1 up to 5 sessions depending on their needs. This session on its own was identified as a sort of therapy by some of the individuals, recognising the Officer as someone non-judgmental who wanted to help. Matching the needs of the individuals to the services available and sometimes accompanying them to the first sessions is also an important input.

National Health Service

This project was funded by the Intermediate Care Fund initially, managed by the North Wales Social Care and Well-being Services Improvement Collaborative which includes Betsi Cadwaladr University Health Board. Then a further 18-month funded has been given directly by the Arfon cluster group. However, this funding is already included as an input under Mantell Gwynedd, and does not therefore need to be included again. In addition to necessary funding, a good working relationship between GPs and other clinical staff and the Community Link Officer, along with their willingness to refer individuals is essential towards the success of this project.

However, given the need for health care professionals to make referrals and spend time with the Officer, it is appropriate to include an additional input that values this time contribution. Therefore, the approximate cost for each referral agent is calculated (table 4) for example,

based on the opportunity cost of not providing services directly to other individuals, the cost of a typical GP appointment of £38[17] is employed for referrals from this source.

Total monetised inputs

The total inputs for the project over the 27-month period have been calculated as £143,195 created by both financial and non-financial inputs from the range of stakeholders above. This information is displayed in table 5, and is compared to the costs per individual.

Table 4 – Value of time taken for referrals

Referral agent	Task	Value	Source
General Practitioner	Initial referral – estimated 10 minutes each.	£38 per GP appointment – used to represent 1 appointment missed per referral made (96 referrals X £38). Therefore, total of £3,648	PSSRU Health and Social Care Costs 2017 page 162
Mental Health Team	Initial referral – estimated 10 minutes each.	£44 per hour per team member of the community mental	PSSRU Health and Social Care Costs page 188

[17] Curtis, L. Burns, A. (2017) Unit Costs of Health and Social Care 2017. PSSRU.

		health team for adults with mental health problems (43 referrals X (£44/6)). Therefore, total of £315	
Adult, health and well-being Services, Social Services	Initial referral – estimated 10 minutes each.	£43 per hour of individual-related work (63 referrals X (£43/6)). Therefore, total of £452	PSSRU Health and Social Care Costs page 174
Occupational Therapists	Initial referral – estimated 10 minutes each.	£42 per hour of local authority operated occupational therapists 32 referrals X (£42/6)). Therefore, total of £224	PSSRU Health and Social Care Costs page 177
Support Workers	Initial referral – estimated 10 minutes each.	£54 per hour for family support worker used (4 referrals X (£54/6)). Therefore, total of £36	PSSRU Health and Social Care Costs page 180

Table 5 – Total Monetised Inputs for Social Prescribing

Stakeholder	Financial input	Non-financial input	Cost per individual
Individuals / Patients	N/A	Willingness to take part and take action identified with the Community Link Officer	N/A
Mantell Gwynedd – manage funding by the Intermediate Care Fund (9 months)and Arfon Cluster for the other 18 months.	£138,520	Strategic management, time, expertise	
NHS	(138,520 funding but included above)	£4,675 of value for the time taken to refer people to Community Link	
Totals	£143,195		£363 per individual

5.0 Outputs, Outcomes & Evidence

The immediate outputs for the Social Prescription, Community Link project, is the number of referrals made to the project and how many hours of support each person received from the Community Link Officer. Over the 27 month period there were 394 referrals made to the

project who were all contacted, by July 2018 there were 366 referrals, and then an estimated 28 further by Sepember 2018. Table 6 below shows a breakdown of how individuals where referred to the project. A small percentage do not meet the Community Link Officer on a face to face basis, as the information given to them via phone seemed to be sufficient. This is relevant to about 5% of individuals, however, they are still logged has having a service and a review will still happen to see if there are any positive outcomes.

Table 6 – Source of referral

Source of Referral	Number of Individual Referred	Percentage of referrals
GP	96	24%
Mental Health Team	43	11%
Adult, health and well-being Services, Social Services	63	16%
Occupational Therapists	32	8%
Self-referral (card by GP)	98	25%
Support Workers	4	1%
Other	58	15%

Individuals can have between 1-5 sessions with the Community Link Officer, depending on their needs. The average number of sessions was 3 meeting, so usually 3 hours contact time per individual. Time would also be spent gathering information on the individual's behalf, arranging appointments and making enquiries. The total average hours provided to support each individual is therefore 5 hours.

Following the contact with the Community Link Officer, an action plan will be jointly made, where individuals can start getting involved in various activities depending on their needs.

A Chain of Change for the individual can be seen in Appendix 2 which shows the story of what can happen for individuals, and Table 7 below summarises all the stakeholders, their outputs and looks at all possible outcomes considered after engagement with all stakeholders. Consideration is given to what will be included and excluded and can then be seen in the Chain of Change.

Case study

A referral was initially made from the GP for a lady with an early diagnosis of Alzheimer's, but during the initial assessment, support was also offered to her husband who was also her carer.

He explained the loneliness he felt at the time of diagnosis when he suddenly needed to know about a new world which he had very little knowledge of. Through the Community Link Officer's support, he's been in touch with Carers Outreach, Alzheimer's Society and attended many events that helped to grow his understanding about the condition. He felt the reassurance of knowing that help is available, and that others are also on the same journey.

Through the support also, he's recognised that he is allowed respite every few weeks and shouldn't feel guilty about that as it benefits everybody. This support and allowing himself time has helped to improve his mental health.

This was an example of how the project not only benefited the wife but the whole family.

Table 7 – Stakeholder Outcomes

Stakeholder	Outputs	Outcomes	Included / Excluded
Individuals	Referral made from the GP or social services. Initial contact with Community Link Officer with an average of 3 hours contact time.	Reassurance of being less alone in their situation	Excluded – individuals can feel this sense of reassurance from their first contact with the Community Link Officer. However, this isn't a key outcome and might only last while in contact with the officer. This is included in the Chain of Change.
		Satisfaction from knowing they have something to look forward to	Excluded- This is an intermediate outcome that leads to all the ultimate outcomes of this project. Many individuals explained how having something to look forward to lead to them feeling much happier and more hopeful about the future.
		Improved financial situation	Excluded – Many of the individuals received support in sorting out their finances, which was having a negative impact on their health. This is an important outcome but leads to the outcome of improved mental health. In the data collected many noted Debt concerned as 'not applicable' and therefore although it was relevant for some, it wasn't for many others.
		Improved housing	Excluded-This was relevant to many but not significant, but also leads to the ultimate outcome of improved mental and physical health.
		Improved mental health	Included – this is a key outcome experienced by some individuals and is both significant and relevant.
		Increased social interaction	Excluded - This is an intermediate outcome that leads to all the ultimate outcomes of this project. Many individuals explained how having something to look forward to lead to them feeling much happier and more hopeful about the future.
		Increased skills due to training and volunteering	Excluded – although this was relevant for some it was not significant.

		Increased confidence to try new things	Excluded - This is an intermediate outcome that leads to all the ultimate outcomes of this project. Many individuals explained how having something to look forward to lead to them feeling much happier and more hopeful about the future.
		Reduced loneliness / isolation	Included – this is a key outcome experienced by some individuals and is both significant and relevant.
		Improved Physical health	Included – although many of the individuals are living with long – term physical conditions, the support given by the Community Link Officer to introduce some changes had a positive impact, and helped ensure more physical movement.
NHS	Reduced demand on services	**Reduced demand on GP appointments**	Included – although it is early to identify changes, some data was available as well as using data from other social prescribing models to forecast the results.
		Reduced demand on appointment with Nurse	Excluded - Although some data available, not enough yet to include in the impact map so will focus on the outcomes for the individuals currently.
		Reduced demand on Emergency hospital visits	Excluded - Although some data available, not enough yet to include in the impact map so will focus on the outcomes for the individuals currently.
		Reduced demand on Out-patient hospital appointments	Excluded - Although some data available, not enough yet to include in the impact map so will focus on the outcomes for the individuals currently.
Social Services	Reduced demand on services	Reduced number of visits by Social Worker.	Excluded - Although some data available, not enough yet to include in the impact map so will focus on the outcomes for the individuals currently.

Outcomes and Indicators

As highlighted, it is only by measuring outcomes that we can be sure that activities are effective for those that matter most to this project. This section of the report highlights the outcomes experienced for each material stakeholder, and also examines those outcomes that represent end-points in the chains of changes for each stakeholder (and are therefore included on the Value Map). Identifying specific outcomes is essential to understand what has changed as a result of activities, yet it is not always an easy task to identify the causal links between the various stakeholders and their outcomes. Appendix 2 illustrates the overall chains of change for those involved in Community Link project, and highlights both those included in this discussion and those excluded from analysis.

5.1 Individuals

Outcome 1 – Reduced loneliness and isolation

One of the main objectives of the project is to support individuals who have social and emotional needs and to reduce demand on statutory services. Loneliness and isolation can have impact on many individuals of any age, gender or other social economic factors. Questions were asked to the individuals about their level of social interaction, about feeling part of the community and about time spent with others. In the second review questions was asked more specifically about what activities they are now part of, any new groups they might be involved with and how often.

In the Arfon project, there were various reasons why people found themselves feeling lonely and isolated which included caring duties, physical and mental health conditions, or living in rural areas with limited transport opportunities.

One individual explained how his disabilities has restricted him from going out from his home over the years and how he became very isolated,

"Can you imagine what it's like not to speak to anybody for a whole month"

When looking at a sample of individuals during the analysis, 53% experienced positive change in reducing their isolation and loneliness, with a distance travelled of 25%. As they would continue to take action and hopefully continue to attend new groups and make new contact, this is likely to continue and improve to a higher percentage of change.

One client during the qualitative research explained how she was isolated due to a chronic illness, and how this service had allowed her to find solutions in the community. She now goes to a group on a weekly basis and had just been on a trip which clearly had a positive impact on her,

"It's a reason to get up in the morning, and it's better than any drug."

As discussed above, time can be seen as something that was important here. Due to the pressures on statutory services, time is very limited which can lead to feelings of isolation and loneliness. Having time with the Community Link Officer and then time to spend with community groups and activities, individuals were able to feel less isolated and lonely. The difference between social prescribing and attending a GP surgery is discussed in the NHS report based on developing a Social prescribing approach in Bristol[18]. In the report, one of the GPs discussed how the social prescribing model allows individuals the time to discuss their problems more explicitly and the officer is able to get "under the skin and find out what makes people tick, what their stresses are

[18] Gray, C. (2013). Developing a Social Prescribing approach for Bristol. Bristol Health and Wellbeing Board.

in life and what resources already exist to help." (p.25 Developing a Social Prescribing approach for Bristol.)

Reduced loneliness and isolation is also an outcome identified by the Rotherham Social prescribing model[19]. For many, they didn't realise this was a problem until they started to see the positive changes, but is seen by many as the first step to change and knowing what is available for them across all sectors, which also includes welfare benefits, which was also identified in the Arfon project.

Outcome 2 – Improved mental health

Questions were asked to individuals about their situation around financial worries, housing, stress and anxiety and feeling part of the community. These are all indicators that can be evidence about their state of mental health, but questions around health were also asked or discussed specifically.

One individual expressed feeling much less anxious, and also feeling generally happier as he now has things to look forward to. He also expressed the feeling of reassurance at having somebody to talk to who has the time. When dealing with statutory services he always feels rushed and doesn't have time to express his needs.

"People don't realise how valuable it is."

Another individual also explained that immediate outcome of reassurance and satisfaction that there are opportunities available for him.

"It's a push to start me on the ladder in the right directions."

[19] Dayson, D. Bashir, N. (2014). The social and economic impact of the Rotherham Social Prescribing Pilot: Main Evaluation Report. Sheffield Hallam University.

Improvement in well-being and especially mental well-being was also identified in the Social and Economic impact report of the Rotherham Social prescribing model[20]. Similar to the Arfon project, individuals identified these opportunities as a starting point towards positive changes.

"Since being referred to Social Prescribing individuals' and carers' mental health has improved, they have become more independent, less isolated, more physically active, and have begun engaging with and participating in their local community." (p.36.)

51% of clients reported a positive change in the their mental health, with a distance travelled of 28%. One client interviewed, explained how her health was deteriorating and she had never Having been independent for most of her life, asking and receiving help wasn't easy. However, following a brain injury, her health started to deteriorate quite rapidly and she realised that she needed support.

She felt *reassured that she now knows where to get help* if she needs it. Previously she was unaware about many of the services, and now she has various different support within her home and the community. She also *feels less concerned and reassured that many of the worries she had are sorted*, and she explained how this was a weight lifted of her shoulders,

"Rhian has been a lifeline really."

Outcome 3 – Improved Physical Health

Many of the individuals referred to this project are living with various acute and chronic health conditions. This include arthritis, stroke, fibromyalgia, diabetes, epilepsy and mobility problems. Many are also living with a mental health condition which has had an impact on their physical health as a result. As discussed in the introduction, loneliness can also have a negative impact on a person's physical health being linked to high blood pressure and obesity.

[20] Dayson, D. Bashir, N. (2014). The social and economic impact of the Rotherham Social Prescribing Pilot: Main Evaluation Report. Sheffield Hallam University.

Some of the information and the activities introduced by the Community Link Officer can lead to improvements in physical health. One lady suffers from arthritis and has very challenging and stressful situation at home. The Community Link Officer was able to give her information on ways to manage the pain and how to eat healthier. She was also able to introduce her to a local social group where she could go and have a conversation with others and socialise, which has had a positive impact on her mental and physical health.

Due to some of these conditions, individuals will still need to engage with health services, however, introducing small changes and ensuring they have the right information and support will allow them to manage their long-term conditions themselves and reducing their visits to the GP.

The Rotherham Social Prescribing Model[21] used 'lifestyle' and 'Looking after yourself' as two of the measures when measuring change. Increased independence was recognised as an outcome for this model, which can also be identified here due to the improvements allowing them to have better access to services and engaging more with the community due to their improvements in physical health.

Possible negative impacts

As seen in the Chain of Change in Appendix 2, for individuals who do not follow the path to successful change, for some there will be no change or possible negative outcomes. Considering the possible negative outcomes is important to allow the organisation to manage these in the future.

[21] Dayson, D. Bashir, N. (2014). The social and economic impact of the Rotherham Social Prescribing Pilot: Main Evaluation Report. Sheffield Hallam University.

Dependency

Many of the individuals were dependant on statutory services such as the GP in the past, and for some this was due to needing to communicate and have time with others. Ensuring individuals do not become dependent on the Community Link Officer is important, however, this is managed currently by ensuring that individuals are aware of the short-term contact with them but that leading to a long-term plan by integrating into current services available within the community.

During the review meetings, the Community Link Officer has a conversation with the individuals to understand what has changed, if any, and further plans for the future. A small percentage of them expressed that they would like further support during these meetings.Looking at the data – approximately 5 % will be re-referred either through the traditional routes, or will ask for more support when the Officer contacts them as they need a few more action points to continue their journey to better health. This shows the importance of maintaining contact as some individuals will need that extra support, and also incidents will happen in their day to day life which means that they will need support from time to time. Some individuals expressed the reassurance they felt from knowing they could just pick up the phone to the officer if needed.

Inapproporiate referrals?

Looking at the sample of data, 45 % of clients experienced no change, which represents 177 of individuals. Consideration should be made as to why these individuals don't experience any change and if inapproporiate referrals are being made to the project. As seen in the Chain of Change, we need to consider all financial and non-financial input from every key stakeholder. If individuals aren't able to make changes then the outcomes would not realise. However, recognition should also be made that for some, without the support, it is possible that their

mental and physical health cold have deteriorated over time, and that for some value can be in maintaining the situation and preventing deteriorating.

One individual we spoke to explained how her life was chaotic at the moment and that without the support things could have escalated. Consideration might need to be given to the two groups of clients referred to the project;

a) Clients who need support to make changes in their lives that will help to introduce positive and sustainable changes which could include reducing loneliness and even entering training or employment.
b) Crisis clients – those clients referred who needs immediate support, but because of their situation, may not experience positive changes, but the service could prevent things from deteriorating and needing statutory support.

There were also examples of people with terminal illnesses where the Community Link officer could offer some initial advice and support, however, their need for statutory support would naturally remain the same or increase.

The diagram below demonstrates the different journeys experienced by clients. This isn't an accurate measurement but is intended to demonstrate the different routes clients can take. For those experiencing a positive change, we can see how over time their outcomes will improve. For some where the project doesn't work for them, they could deteriorate as they've tried to make changes and it didn't work and therefore could feel worse as a result. For those with no change, the straight line demonstrates this, however there is a line to demonstrate' potential change without support'. Some clients expressed that their lives were still chaotic and suffered from various physical, mental health issues that were beyond their control, or concerns such as housing and debt. However, they did explain how without this support, things would have deteriorated.

Increased feeling of loneliness due to the project not working for them

As with many projects, this will not work for everybody. However, by raising somebody's expectation and that leading to no change, there is a possibility of somebody feeling worse due to having tried something and not being successful. This can lead to increased feelings of loneliness due to hopes being raised of social interaction possibilities, but then disappointment when this did not realise. Care must be taken therefore potentially in the selection of individuals, and also in the management of expectations. Due to some not having any change in the second review, and other not been available for a second review a judgment of 3% is taken here of those having a second review.

Results by stakeholder groups

Not all of our clients are the same, and some will have different needs and will experience different results. Consideration will therefore be given to different stakeholder segments to understand if there are differences in the results and could demonstrate a need to manage the

service differently for different segment of stakeholders. Table 8 and 9 below summarise the results based on the sample data with baseline and distance travelled results of 98 clients.

Females have a slightly higher distance travelled than the males, but the percentage experiencing positive change is very close and therefore it doesn't suggest any high variances here. Considering the results for the different age categories, some age groups have a higher percentage of positive change. If we compare the 18-40 category with 38% positive change compared to 61-70 year olds experiencing a 72% change.

Table 8 – Results based on gender

Gender	% represented in sample	% positive change	% distance travelled
Male	33%	51.5%	25%
Female	67%	53%	30%

Table 9 – Results based on age

Age Category	% represented in sample	% positive change	% distance travelled
18-40	14%	38%	24%
41-50	10%	56%	24%
51-60	18%	47%	28%
61-70	12%	72%	28%
71-80	15%	43%	37%

81+	31%	60%	22%

Further consideration should be given to the differences in results here based on age to explore if any further support can be given for younger individuals, or any partnership working.

5.2 Health and Social Care

Reduced Demand on Services

All outcomes to the NHS and Social Services relate to the potential for cost reallocation related to avoided demand on services. The main objective of the project is to reduce demand on statutory services by supporting those who regularly use services but who could use other services or take part in other activities to better manage their social, physical and emotional needs. The material outcomes for the individuals will therefore have impact on services, and evidence from this analysis and from other previous studies was used to make conservative estimates.

A theme that emerges through this analysis is time. The individuals' needs time to engage with people due to their emotional needs. Feeling isolated and lonely for various reasons, many engaged with services as they need to communicate with someone and need reassurance from others. However, due to increased pressure on services, time is something that is limited for GPs and Social Workers, they are therefore unable to give them the time to carefully identify the core of the individuals' issues. By having more time to engage, the Community Link Officer is able to gain an understanding of their needs and to find suitable solutions which reduces demand on the health and social care services.

One individual had a medical condition that means he needs to attend appointment on a monthly basis that will not change. However, due to him feeling lonely and isolated he used to also call the surgery on a regular basis. Since receiving support from this project, this has now stopped, and so dramatic was the change that the surgery staff decided to make enquiries about his welfare as it was so unusual for him not to call. This has relieved some time for the staff, but also is an indicator of the positive changes in his life.

However, although some changes have been identified, more time is required to see more significant change, so a forecast is provided based on a small sample data, but also by using current data available from other social prescribing models.

The Rotherham Social Prescribing Model[22] focused more on reduced hospital admissions rather than GP visits, looking at inpatients, outpatients and A&E attendees. There was an overall reduction of 21% after 12 months of being referred to the social prescription service. We analysed the baseline data for individuals on the Community Link Project and saw that individuals visited the GP on average 22 times a year. We looked at a sample of 71 individuals to see how often they used the GP surgery at the start of the service and after a few months following intervention from the Community Link Officer. The table below summarises the results.

[22] Dayson, D. Bashir, N. (2014). The social and economic impact of the Rotherham Social Prescribing Pilot: Main Evaluation Report. Sheffield Hallam University.

Sample of 71 individuals			
Positive change	57	78%	12.6 less appointments per individual receiving positive change
Negative change (more use of services but not necessarily negative at all)	9	12%	12.5 more appointment per individual
No change	7	10%	

For those that had positive change (78%), they now use the GP on average 12.6 less appointments per year based on the change they had identified. When data analysed in June 2017, this also demonstrated the same reduction rate. This means that 3,872 appointments less are potentially being used due to this preventative service. However, 12% were now using the services more often, and this was an average of 12.5 more appointment per individual. Further research is needed to understand the reasons for this, but based on communication with the Community Link Officer for many this was a positive thing as they needed to go to the GP more often for medical reasons. A further 10% had not experienced any change in their use of service, again this might be for reasons that attending the GP is necessary.

Case study

After suffering from a breakdown and severe depression, this lady was referred to the project by her GP. Having moved to a new area and dealing with many changes in her life, she needed some support and guidance.

The Community Link Officer gave her some practical support first of all in the house with unpacking so she could get settled. She explained how she immediately started to feel better because of the help that was available,

“My spirits starting coming up, and also it was nice having company.”

She was given an information pack with all the support available to her which included support for the home from Gofal a Thrwsio (Care and Repair) and Nest to support with energy efficiency.

She explained how she felt much better now and how her confidence had grown and as a result has been able to find part time employment. All these positive changes has resulted in her medication being reduced, and when we asked what she thought could have happened without this support, she expressed that she feared that things would have continued to deteriorate and she felt she would have had to go back to hospital.

This case study showed how some practical and emotional support had helped to take those first steps to positive change and how that continued as she gained employment and became more sociable.

6.0 Valuing Outcomes

The difference of using SROI to other frameworks is that it places a monetary value on outcomes. By using monetisation, it allows us to not only give the story of what's changed in people's lives, but also allows us to put a value on these changes so we can compare costs and outcomes. This isn't about putting a price on everything, but it allows us to demonstrate what impact the service has on other stakeholders and possible savings an intervention can create. It also goes beyond measuring, and allows organisations to manage their activities to ensure the best possible impact is created for those that matter to them the most, the individuals.

Impacts of Arfon Social Prescribing pilot

SROI analyses uses accepted accounting principles to calculate the overall impact of activities. Taking into account any deadweight, attribution, displacement and drop-off factors, means that SROI analyses will avoid over-claiming value that is not a result of the activities. The boxes below outline each of the impact factors.

Deadweight

This asks the likelihood an outcome could have occurred without an activity taking place. So, for example if it is believed that there was a 10% chance that someone could have found work without a training programme, the value of that outcome is reduced by 10%.

Attribution

Considers what proportion of an outcome is created by other organisations/individuals, so can therefore not be legitimately claimed by the SROI analysis. For example, if external agencies also support someone receiving training, that organisation is responsible for creating some of the value, not just the training organisation.

Displacement

This asks if an outcome displaced similar outcomes elsewhere. This is not always a necessary impact measure, yet must be considered. For example, if a project reduces criminal activity in one area, which results in increases in other locations, there is a need to consider the displaced outcomes.

Drop-off

Outcomes projected for more than one year must consider the drop-off rate. This is the rate at which the value attributable to the focus of the SROI analysis reduces. For example, an individual who gains employment training may in the first year of employment attribute all of the value to the training organisation, but as they progress in their career less value belongs to the initial initiative owing to their new experiences.

Stakeholder 1 –Individuals

The valuations for the outcomes identified to the individuals were taken from HACT'S Social Value Calculator (version 3)[23] that identifies a range of well-being valuations. However, the data from the initial assessment and second review provided a distance travelled on how much change had been experienced, therefore a proportion of the wellbeing valuations were used accordingly.

The valuation for Reduced Isolation / Loneliness was taken from the outcome 'Talks to neighbours regularly' as a well-being valuation. There were other valuations on Global Value Exchange[24] that was much higher than this, such as the wellbeing valuation for Loneliness (change in) for older people values at £15,666 (http://www.globalvaluexchange.org/valuations/8279e41d9e5e0bd8499f2cd8). We also considered taking the value from the Ffrindia' SROI report[25] on loneliness that was taken from using the Value Game with the individuals that were befriended, which was a value of £5,580. Following the principle of not over-claiming, the lower value from HACT is used.

The value for Improved mental health (HACT Code HEA1602 Relief from depression / anxiety) and Improved physical health (HACT Code HEA1603 - Good overall health) also uses well-being valuation. It should be noted that the value here is much higher than for Reduced Loneliness. When having more time to identify changes, individuals should be asked to rank their outcomes in order of importance, as currently the values might not represent this.

Due to this being a short-term pilot, using already existing well-being valuations allowed us to establish the Social Return on Investment for this project. However, in the longer term, the

[23] HACT well-being valuations. Available at http://www.hact.org.uk/value-calculator
[24] Global Value Exchange www.globalvaluexchange.org
[25] Richards, A. (2016). Ffrindia' Social Return on Investment Report – The Value of Friendship.

value game will be used with individuals to ensure that stakeholders are involved at each stage and to ensure that stakeholders are involved at each stage (Principle1).

It can also be noted here that due to the high value given to Improved mental health, a higher attribution is given to ensure a more realistic figure.

Stakeholder 2 – Health and Social Care

To put a value on the reduced potential demand on the NHS, the published Unit Costs Health and Social Care 2017, by PSSRU[26] was used. Individuals were asked if there were any changes in their use of health and social care services. An average GP visit will cost £38 and will last on average 9.22 minutes. By taking a sample of the individuals and analysing the data given in the initial meeting and at the second review an estimation of potential savings to the NHS was made. Based on 78% of individuals receiving some form of positive outcomes in that they use services less often a judgment was used to say there would be 3872 less appointments taken up per year as a result of these services which is an average of 12.6 less appointments for those individuals that have had a positive change in their lives as a result of the social prescribing model. However, we have also included that some individuals used the services more often, and based on the sample of 12% in this category, this gave a total of 591 appointments that need to be deducted from above. Table 10 shows how some of the individuals' outcome valuations have been calculated.

[26]Curtis, L. Burns, A. (2017) Unit Costs of Health and Social Care 2017. PSSRU.

Table 10 – Examples of Outcome Valuations

Outcome	Identified value	Value of average distance travelled	Quantity of stakeholders experiencing outcome
Individual; Reduced loneliness and isolation	Used HACT Code ENV1410, talking to neighbours regularly valued at £4,511 for unknown area. Took 25% of this value based on the distance travelled, therefore £1,128.	Taking the lowest point for our questionnaire scale asking individuals to rate against measures (very poor =0%, poor= 25%, ok = 50%, good = 75%, very good = 100%) The average movement was 1.27 point – which equals 25% Although based on low sample size the results were in line with tone of interview comments – this was cited as an extremely significant change.	From the data in second review, 53% had experienced change here, so 209 individuals.
Individual; Improved mental health	Used HACT Code HEA 1602, Relief from depression / anxiety valued at £36,760 for unknown area. Took 28% of this value based on the distance travelled, therefore £10,292.	Taking the lowest point for our questionnaire scale asking individuals to rate against measures (very poor =0%, poor= 25%, ok = 50%, good = 75%, very good = 100%) The average movement was 1.42 – which equals 28% Although based on low sample size the results were in line with tone of interview comments – this was cited as an extremely significant change.	From the data in second review, 51% had experienced change here, so 201 individuals.
Individual; Improved physical health	Used HACT Code HEA1603, Good overall health valued at £20,141 for unknown area. Took 24% of this value based on the distance travelled, therefore £4,834.	Taking the lowest point for our questionnaire scale asking individuals to rate against measures (very poor =0%, poor= 25%, ok = 50%, good = 75%, very good = 100%) The average movement was 1.22 point – which equals 24% Although based on low sample size the results were in line with tone of interview comments – this was cited as an extremely significant change.	From the data in second review, 51% had experienced change here, so 201 individuals.
NHS; Reduced potential demand on service	£38 per GP appointment from PSSRU Health and Social Care Costs 2017.	From the baseline data, there was an average of 22 GP appointment by individuals per year. Based on a sample of individuals that had baseline data and a review, there were 78% of individuals receiving a positive change in reducing their need to use GP service.	Considered 78% of individuals that had positive change and reducing appointments by 12.6 appointments each.

7.0 Establishing Impact

In order to assess the overall value of the outcomes of Arfon Social Prescribing Model we need to establish how much is specifically a result of the project. SROI applies accepted accounting principles to discount the value accordingly, by asking; What would have happened anyway (deadweight)? What is the contribution of others (attribution)? Have the activities displaced value from elsewhere (displacement)? If an outcome is projected to last more than 1 year, what is the rate at which value created by a project reduces over future years (drop-off)? Applying these four measures creates an understanding of the total net value of the outcomes and helps to abide by the principle not to over-claim.

Deadweight

Deadweight allows us to consider what would happen if the service wasn't available. There is always a possibility that the individuals would have received the same outcomes through another activity or by having support elsewhere.

The Community Link Officer will refer individuals to services that are already available within the community, so there is a good possibility that individuals could have been signposted to these services elsewhere. However, individuals felt that the Community Link offered more than signposting, and was able to provide a personalised action plan and in some cases, help them with those first steps to receiving a service or taking part in an activity. One individual expressed how he had been referred to different places in the past, but didn't feel it offered a long-term solution like this project did.

Through the interviews with individuals and other stakeholders, and the results of the second review a reasonable estimate is given in table 11 below.

Table 11 – Deadweight value

Outcome	Deadweight	Justification
Reduced loneliness / isolation	30%	The services that the individuals are now or will be engaging with are already available within the community, so some deadweight percentage must be considered. However, barriers that had restricted them in the past meant it wasn't possible, so this project helped to break down those barriers to ensure positive change was created.
Improved mental health	30%	There is a chance that this outcome could have happened anyway through another activity or another organisation, so a 30% deadweight is given.
Improved physical health	30%	It is possible that other organisations could have given the same advice to have a similar impact, or family and friends could have helped. However, barriers that had restricted them in the past meant it wasn't possible, so this project helped to break down those barriers to ensure positive change was created.

Attribution

Attribution allows us to recognise the contribution of others towards achieving these outcomes. There is always a possibility that others will contribute towards any changes in people's lives such as family members or other organisations. Attribution allows us to see how much of the change happens because of the support by this project.

Individuals were asked specifically about how much of the changes were down to this project;

Question 24. Thinking about all of the things that have changed in your life since joining the scheme, how much of this is a result of Community Link (other people or organisations may also be important)? (question taken from individuals' second review)

This project will have very short contact time with the individual due to the nature of the service being to help them to engage with services already available within the community in order to reduce demand on statutory services. Without the organisations that provides these services,

these positive outcomes would not be possible, and therefore a proportionate percentage of the change should be attributed to them. However, it is this relationship between the project and the statutory services that allows these links to happen, and therefore a fair percentage of the change should be given to this project to represent the change that's been created.

"I get out of the house. I meet up with Maria RVS who is great. I have plans to go out for a meal with a group of people. I have information to help me to make my life easier. I have been talking to others re: the project and trying to get an interest in holding a group in Bethesda - lunch groups. There are a lot of people who would support this. Community Link helped a lot with my hearing, arthritis group to socialise. I want to thank you very much for your good work. It has opened doors for me. A lot of the changes are the result of Community Link." (Individual, feedback during second review)

An attribution of 70% is given to the Reduced Loneliness and Improved Physical health and a slightly higher rate of 80% is given to Improved Mental Health. The slightly higher rate is given to this outcome due to the high value that this outcome has due to a lack of another suitable value. This may appear as a high percentage to attribute to others, but again emphasis should be given that without the support of the Community Link Officer, this change may not have happened at all, but in order to not over-claim a higher attribution is given to acknowledge the contribution of all the third sector organisations within the Arfon area.

Displacement

We need to consider if the outcomes displace other outcomes elsewhere. For example, if we deal with criminal activity in one street, have we just moved the problem elsewhere. This model is currently new to the area and provides a link to all other services, and therefore does not displace any.

Duration & Drop-off

The aim of the project is to allow individuals to be better able to manage in the long-term and to ensure that they engage with services within the community as an alternative to medicine. By being more involved in the community and having more social interactions, there should be some long-term changes and benefits to the individual as well as a reduced demand on services. Over time many other factors will contribute towards maintaining these outcomes and therefore this analysis will only consider the value for 2 years. For the second year, a drop-off rate of 60% is given, as the impact created by the project will be reduced over time as the contribution of others will be more visible in maintaining or increasing the amount of change.

8.0 SROI Results

This section of the report presents the overall results of the SROI analysis of the social prescribing model service provided by Mantell Gwynedd. Underpinning these results are the seven SROI principles which have carefully been applied to each area of this analysis. The results demonstrate the positive contribution that the Community Link, Social Prescribing project makes through the dedication of staff to create a positive change in the lives of those with social, emotional and practical needs.

By giving individuals the time to explain their needs are and to reduce possible restrictions they have experienced in the past to access local based services, the Community Link Officer is able to guide them through what is available and assist them with taking the first steps to change. This lead to positive changes in their lives in the short time that we did this analysis, but forecasting that this will continue to improve over time.

Table 12 displays the present value created for each of the included stakeholders who experience material changes. The present value calculations take account of the 3.5% discount rate as suggested by the Treasury's Green Book.

Table 12 - Total Present Value Created by Stakeholder

Stakeholder	Value created as a result of Community Link, Arfon Social Prescribing model	Proportion of total value created
Individuals / Individuals – Positive outcomes	£583,503	96%
Individuals – negative outcomes	-£6,157 (already deducted)	
NHS (Reduced GP visits)	£22,071	4%

Table 13 - Present Value Created per Individual Involved

Stakeholder	Average value for each individual involved
Individuals	£1,900

The above results in table 13 indicate a positive return for individuals who were referred to the Community Link Officer and experienced positive outcomes. This is based on current data but also forecasting results based on secondary research. The overall results in table 14 highlight the total value created, the total present value (discounted at 3.5%), the net present value, and ultimately the SROI ratio.

Table 14 – SROI Headline Results

Total value created	£
Total present value	£748,670
Investment value	£143,195
Net present value (present value minus investment)	£605,574
Social Return on Investment	£5.23:1

The result of £5.23:1 indicates that for each £1 of value invested in Community Link, Arfon Social Prescribing Model, a total of £5.23 of value is created.

9.0 Sensitivity Analysis

The results demonstrate highly significant value created by the Arfon Social Prescribing model provided by Mantell Gwynedd, and is based on application of the principles of the SROI framework. Although there are inherent assumptions within this analysis, consistent application of the principle not to over-claim leads to the potential under-valuing of some material outcomes based on issues such as duration of impact.

Conducting sensitivity analysis is designed to assess any assumptions that were included in the analysis. Testing one variable at a time such as quantity, duration, deadweight or drop-off allows for any issues that have a significant impact on the result to be identified. If any issue is deemed to have a material impact, this assumption should be both carefully considered and managed going forward. To test the assumptions within this analysis, a range of issues were altered substantially to appreciate their impact. A summary of the results is presented in table 15.

Table 15 – Sensitivity Analysis Summary

Variable	Current assumption	Revised assumption	Revised SROI	Proportion of change
Individuals; reduced loneliness / isolation	Quantity; 209	Quantity; 100	4.99	4.5%
	Deadweight; 30%	Deadweight; 60%	5.03	3.8%
	Attribution; 70%	Attribution; 90%	4.92	5.9%
	Value; £1,128	Value; £500	4.97	4.9%
Individuals; Improved mental health	Quantity; 201	Quantity; 100	3.87	**26%**
	Deadweight; 30%	Deadweight; 70%	3.68	**29.6%**

	Drop-off; 60%	Drop-off; 80%	4.85	**7.2%**
	Value; £10,292	Value; £5,000	3.84	**26.5%**
NHS; Reduced demand on service (less GP appointments)	Quantity; 3,872	Quantity; 2,000	5.13	1.9%
	Attribution; 70%	Attribution; 90%	5.25	0.3%

Although some of the sensitivity tests indicate changes to the result, owing to the scale of the amendments made and the verification of assumptions and data with stakeholders, the results still indicate that if a single variable were significantly altered, the overall results remain highly positive. The most significant impact of the sensitivity analysis is based on the change to the outcome for individuals on improved mental health. This could be because of the relatively high value given to this outcome compares to the outcome of reduced loneliness. Again, the sensitivity test uses a relatively large change, and although there is a great deal of confidence in the figure employed, it nevertheless indicates the importance for Mantell Gwynedd to carefully manage this issue in the future.

10.0 Conclusion

This report has demonstrated that Community Link, Arfon Social Prescription Model pilot will create over £748,000 of value and for each £1 invested, £5.23 of value is created;

What that means in practical terms is that people's lives have been positively changed.

Social Prescribing offers an alternative for professional staff working in Health and Social Care and offers a solution for individuals with social and emotional needs. The Arfon Social Prescribing Model works with individuals to create positive changes in the lives of people.

Time is limited for staff working in Primary Care with increasing pressure on services that will continue to be stretched based on the changing nature of the population. Time is something that the Community Link Officer can offer the individuals to understand what their needs are and to work together to find solutions locally. Any barriers which had previously restricted them from attending any local groups or taking part in activities are tackled head on.

There is a vast amount of services available locally, but the Social Prescription model offers the missing link to ensure that those who are most isolated in communities are able to access these services and reduce the pressure on statutory services.

The outcomes wouldn't be possible without the contribution of third sector services that are already available within communities, so a fair amount of the value has been attributed to them. However, the services already existed so having the Social Prescription model ensures that the statutory services are made aware of what is available and can refer to one organisation instead of needing to refer to various service that time doesn't allow.

These outcomes of this project can show the contribution made here towards the National well-being goals as part of the new Well-being of Future Generations (Wales) Act 2015. By offering

individuals an alternative we can contribute towards a more resilient Wales, a healthier Wales and also a more equal Wales where individuals / individuals are given the opportunities to engage more with their community and society.

11.0 Recommendations

1) Mantell Gwynedd is an umbrella organisation for the third sector in Gwynedd and is well placed to advise individuals on services available with no form of bias. Referrals are made to various organisations based on their services and expertise and the Community Link Officer continuously adds different services to the list of what's available as she hears of new groups. However, it is possible that these services can identify increased pressure on their services, without receiving any further funding support. As the project continues, it may be beneficial to ensure regular feedback is given from the organisation to ensure they have the resources to deal with increased referrals.

The Rotherham Social Prescribing model[27] commissions services to deliver the social prescribing model. They have 24 different organisations being commissioned that offers a menu of services and the grant allows them to have the right resources to deal with the increased referrals. This might be something to consider in the future. However, having a restricted number of services could restrict the service, and currently having the vast information of different services available allows the freedom of giving the individual the decision on what service will help them and lead to a positive impact in their lives.

2) Data collection – ensuring we have baseline data and having a mid-review and end review is essential for us to understand if there is any change, but also how much change, and are there differences in the needs of different individuals. It is therefore recommended that any continuation of this scheme, or indeed any other social prescribing, needs to **invest the time and finances into ensuring suitable systems and processes are in place to measure social value**, and also extend this to include other

[27] Dayson, D. Bashir, N. (2014). The social and economic impact of the Rotherham Social Prescribing Pilot: Main Evaluation Report. Sheffield Hallam University.

important stakeholders such as wider family members and unpaid carers. When such data is collected over a period of time, the potential to use resultant information to inform decision-making is possible. Ultimately, this means that value is not just being measured, but it is being managed to improve the impacts of the project.

It was also noted that during the review meetings, that 10% of individuals still felt they needed support, and therefore to understand what changes and to understand perhaps why there hasn't been any change, maintaining this relationship is crucial to develop the service.

3) Focus should be given to look at why 45% experienced no change when they took part in a review meeting. Due to the nature of the service and the problems that might have been present for some time, it may be that further time or support is needed for these clients in order to ensure any changes happen and are sustainable.

   For some clients, they had health conditions, some terminal illness, which meant that although emotional and social support was needed, there would be no impact on their physical health. Some clients explained how things could have deteriorated if it wasn't for the support from the Community Link Officer. This support was both practical (such as arranging house improvements or filling in forms) or social and emotional (such as advising on support groups or befriending). However, consideration should be given to whether this is the right project for such referrals, or should there be two services available – one for people who could introduce changes in their lives that would help to have positive and sustainable changes, and another that support clients in crisis.

12.0 Appendices

Appendix 1 – Project Paperwork

ADNABOD ANGHENION YR UNIGOLYN/IDENTIFYING INDIVIDUALS' NEEDS

Review 1; This form is intended to be used by new starters only

1. Enw / Name	
2. Dyddiad geni / Date of birth	
3. Cyfeiriad / Address	
4. Rhif Ffôn / Phone number	Tŷ / House: Ffôn symudol / Mobile phone:
5. E-bost / E-mail	
6. Ffordd gorau i gysylltu / Preferred method of contact	Ffôn / Phone Text E-bost / E-mail Post Facebook Arall / other
7. Gender	
8. Surgery	
9. Are you a carer?	Yes / No

10. Do you drive?	Yes / No

11. Pa gefnogaeth ydych chi yn dymuno ei gael gan Linc Cymunedol? Pa newid ydych chi'n gobeithio ei wneud? What support do you require from Community Link? What changes would you like to work towards?

13. A ydych yn derbyn unrhyw wasanaeth gan asiantaeth arall? Are you receiving support from any other organisation?				Ydw/Nac Ydw Yes/No
Mudiad/Organisation	Enw Cyswllt/ Contact Name	Cyfeiriad/Address	Rhif Ffôn/Phone	Math o gefnogaeth Type of support

12. Are there any sorts of activities or things you would like to participate in?

15. Unrhyw sylwadau ychwanegol e.e. sefyllfa gymdeithasol/meddyginiaeth. Any other information e.g. social situation/medication

16. Thinking about what you might gain from involvement with Community Link, could you please rate your current situation for each of the below items (they may not all be relevant of course).						
	Not applicable to me	1. Very concerned	2 A bit concerned	3 Neutral	4 Not concerned much	5 Not concerned at all
Concerns about debt						
	Not applicable to me	1 Very poor	2 Poor	3 Ok	4 Good	5 Very good
Physical health						
Stress, anxiety, depression or similar						
Time spent with other people socialising						
General confidence						
Feeling part of the local community						
Housing situation						

Employment situation						
Skills / education						
Other (please state)						
Other (please state)						
Other (please state)						

17. Thinking back over the last 12 months, how often have you used the following services?								
	Not used in the year	More than once a week	Once a week	About once every 2 weeks	About once a month	About once every 3 months	About once every 6 months	About once in 12 months
General practitioner								
Local nurse services								
Social Services								
Emergency hospital services								
Out-patient hospital services								

Carers Trust or similar								
Other								
Other								

Llofnod Cydlynydd/ Coordinators Signature		Dyddiad/Date	

ADNABOD ANGHENION YR UNIGOLYN/IDENTIFYING INDIVIDUALS' NEEDS

Review 2; (2-3 months after referral)

18. Pa brif newidiadau ydych chi wedi ei adnabod, os o gwbl, yn yr wythnosau /misoedd diwethaf? What main changes have you experienced, if any, in the past few weeks / months?

19. A ydych yn derbyn unrhyw wasanaeth gan asiantaeth arall? Are you receiving support from any other organisation?				Ydw/Nac Ydw Yes/No
Mudiad/Organisation	Enw Cyswllt/ Contact Name	Cyfeiriad/Address	Rhif Ffôn/Phone	Math o gefnogaeth Type of support

20. Have you joined any *new* groups or started *new* activities (for example, joined the library, the choir, lunch club or started volunteering) since joining the project? And if so, how often do you undertake these activities?						
No		More than once a week	Once a week	Once every two weeks	Once a month	Less than once a month
Yes (please state below)						
1.						
2.						

3.						
4.						
5.						

21. As a result of the support from Community Link have you learnt about new services that are available to you within your community?	
No	
Yes (please state)	

22. Thinking about what you have experienced as a result of involvement with Community Link, could you please rate your current situation for each of the below items (they may not all be relevant of course).						
	Not applicable to me	2. Very concerned	2 A bit concerned	3 Neutral	4 Not concerned much	5 Not concerned at all
Concerns about debt						
	Not applicable to me	1 Very poor	2 Poor	3 Ok	4 Good	5 Very good
Physical health						
Stress, anxiety, depression or similar						
Time spent with other people socialising						
General confidence						
Feeling part of the local community						
Housing situation						
Employment situation						
Skills / education						
Other (please state)						

Other (please state)						
Other (please state)						

24. Thinking about all of the things that have changed in your life since joining the scheme, how much of this is a result of Community Link (other people or organisations may also be important)?	
All of the changes are the result of Community Link	
A **lot** of the changes are the result of Community Link	
About **half** of the changes are a result of Community Link	
A **little** of the changes are the result of Community Link	
None of the changes are the result of Community Link	

25. Have you experienced any negative changes as a result of being involved in the scheme?	
No	
Yes (please state below)	

23. Looking back over the last 6 weeks, how often have you used the following services?						
	Not used in the time	More than once a week	Once a week	About once every 2 weeks	About once a month	Once in 6 weeks
General practitioner						

Local nurse services						
Social Services						
Emergency hospital services						
Out-patient hospital services						
Carers Trust or similar						
Other						
Other						

Llofnod Cydlynydd/ Coordinators Signature	
Dyddiad/Date	

Appendix 2 Chain of Change – Individuals / individuals of Social Prescription Model