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COMMUNITY LINK SOCIAL IMPACT REPORT 2020-2021

"The support and information I have received over the years has saved my life. I now feel I have some control back, and looking to the future on how I can keep going forward"

SOCIAL VALUE CYMRU

Introduction

Community Link 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 needs of individuals are identified and then activities and services are offered and an action plan agreed on together. , As the individuals become more engaged with services within their communities, reduced demand on statutory services such as the NHS and Social Services is identified.

A full report on the initial three years of this project was published in September 2018, an interim report was then produced in September 2019 & September 2020. This current report will analyse the social impact of the Community Link project in Arfon provided by Mantell Gwynedd between the October 1st 2020 and the 30th September 2021. It should be noted that COVID -19 again had an impact on the service that the Community Link Officer was able to provide during this period due to a 'firebreak' lockdown in Wales (October 23rd 2020 – November 9th 2020) and a second national lockdown (December 20th 2020 – April 26th 2021) which impacted on clients and particularly the ability for the Community Link Officer to meet with clients. Since the start of the pandemic the Community Link Officer has not been able to visit any clients on a face to face basis. The impact of this service on individuals will be considered, but also the value to other statutory services, especially the health board.

Through engagement with individuals receiving the services and referral organisations, and from examination of information and data available, appropriate estimations have been made, supported by secondary evidence.

Continued impact of Covid-19 on the service

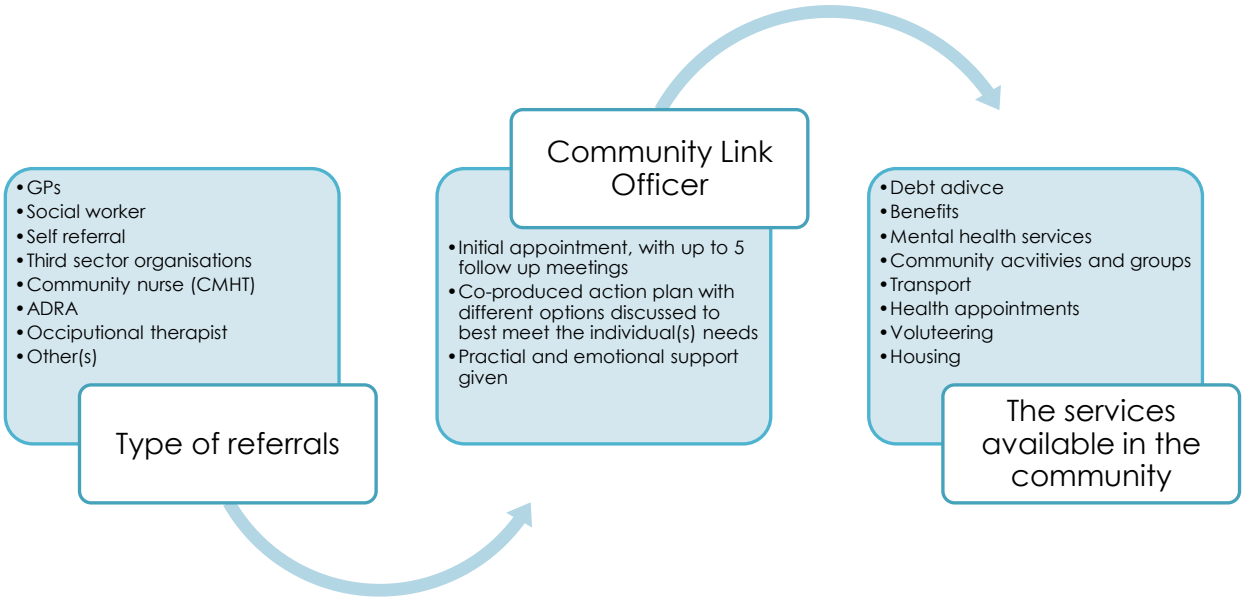
It should be stated that the project has evolved over the last 18 months. Since March 2020, due to the Covid-19 pandemic, the project became mainly a service to support people facing a crisis at the time. At the point of crisis many people feel they have no-one to turn to, and this is where the Community Link officer provides a vital role/service. With no social groups and face to face interactions possible due to the restrictions, the service had to adapt and support individuals where possible. The continued support provided by the Community Link Officer during the past 12 months has been crucial for some clients' mental wellbeing, helping with reducing the feeling of isolation and loneliness, reducing anxiety, and helping alleviate stress, the focus of the report will analyse and discuss the positive mental health impact the project has created for the clients. At the point of crisis, the impact of the project can be seen as the clients not going into further crises, therefore reducing any further potential negative impact.

Due to the second national lockdown and continued restrictions over the past 12 months, there are still no face-to-face appointments at present. Appointments are still via telephone, with some being provided virtually via Zoom. The Community Link Officer has still spent up to 5 hours of contact time with clients via telephone, however, in some complex cases more contact time is needed.

The types of services available to support clients was also considerably different due to Covid-19. Clients supported by the Community Link Officer are those individuals who are lonely and isolated within communities, and unfortunately Covid-19 has further intensified these circumstances for many Other changes to the service included the ability of the Community Link Officer being able to signpost clients to other services in the community as those services had also either ceased or changed in the way in which they were delivered, with many of the services still not able to see clients face to face. There has been a rise of individuals needing mental health support. A factor to this can be related the average age of the clients. Most of the clients supported on the project are over

65+ years old. As the age group are at a higher risk of suffering serious health issues, due to covid-19 many individuals are still scared to go out and socialise, thus having an impact of their mental health.

Process of Referral



Project Inputs

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. Several of the individuals had likely been isolated for some time prior to national lockdown due to their mental and/or physical health matters.

The financial input is managed by Mantell Gwynedd. A financial input of £57,000 was provided for the 12 months period of analysis, funded by Betsi Cadwaladr University Health Board (BCUHB).

Because of the need for health care professionals and other organisations 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 1) for example, based on the opportunity cost of not providing services directly to other individuals, the cost of a typical GP appointment of £39.23[1] is employed for referrals from this source. Total costs for the project can be seen in table 2.

Table 1 – Referral costs

Referral agent	Task	Value	Source
General Practitioner	Initial referral – estimated 10 minutes each.	£39.23 per GP appointment – used to represent 1 appointment missed per referral made (**21** referrals X £39.23). Therefore, total of £823.83.	Unit Costs of Health and Social Care 2020 PAGE 126
Adult, health and well-being Services, Social Services	Initial referral – estimated 10 minutes each.	£46 per hour of individual-related work (**20** referrals X (£46/6)). Therefore, total of £153.33	PSSRU Health and Social Care Costs page 115
Occupational Therapists	Initial referral – estimated 10 minutes each.	£44 per hour of local authority operated occupational therapists **3** referrals X (£44/6)).	PSSRU Health and Social Care Costs page 129

[1] https://www.pssru.ac.uk/pub/uc/uc2020/2-communityhcstaff.pdf

		Therefore, total of £22	
Other services	Initial referral – estimated 10 minutes each	£8.91 per hour based on current living wage **(33** referrals x (8.91/6)) therefore total of £49	Gov.co.uk [2]

Table 2 – 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	
Mantell Gwynedd – manage funding by BCUHB	£57,000	Strategic management, time, expertise	
NHS	£1,048 in addition to the funding	£1,048 of value for the time taken to refer people to Community Link	
Totals	**£58,048**		**£390 per individual**

[2] https://www.gov.uk/national-minimum-wage-rates

Outputs 2020-2021

The 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 12-month period October 2020 – September 2021 there were **149 referrals.** In total, since the launch of the project in June 2016, 1,135 individuals have been supported through the programme**.** However, in 2020 -2021, 14% (20) of referrals are re-referrals and therefore we will consider the value for 129 individuals over the 12 months. Table 3 below shows a breakdown of how individuals were referred to the project.

Table 3 – Source of Referral

Source of Referral	Number of Individual Referred	Percentage of Referrals
GP	21	14%
Mental Health Team	17	11.5%
ED (WEDFAN)	3	2%
Occupational Therapists	3	2%
Self-referral (card by GP)	52	34%
Other services	33	22.5%
Re-referrals	20	14%

Individuals benefit, on average, from 1–5 sessions via telephone with the Community Link Officer. Face to face appointment are still not viable with current Covid-19 restrictions. Contact is very much determined by their needs. The average number of sessions was 3 meetings, so usually 3 hours of contact 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 everyone was therefore 5 hours per case.

Following contact with the Community Link Officer, an action plan is jointly agreed, where individuals start getting involved in various activities and/ or organisations depending on their personal needs.

21 GP referrals were made to the Community Link Officer during the period which reflects the reduction in face-to-face GP appointments and the reduction in general of those attending GP surgeries. This is an increase from 4 GP referrals to the project last year. As restrictions continue to ease, the number of GP referrals to the project may increase further, perhaps to pre COVID levels.

"I think it is likely that the time Rhian spent with Patient A, listening to, and validating her is likely to have had a major contribution to her not contacting us out of hours as often (she will occasionally have to) Thank you, Rhian."

Out of Hours GP

Outcomes

All the data for the outcomes is collected and analysed through the Elemental platform. Using the database, we can track the progress and level of change clients have or are going to experience throughout the year, using ONS 1234 data collection point. The ONS measurement do not go hand in hand with the outcomes identified in this report, this is due to outcomes in Social Return on Investment reporting needing to being more well-defined outcomes to better understand and measure the social impact created. Although, it must be stated that we have a system in place to ensure the data collected via Elemental can be used for the SROI reporting, with Elemental being a good toolkit to gather more information and better analyse the extent of change experience by the clients.

It is only by measuring outcomes that we can be sure that activities are effective for those who matter most to this project. The well-defined outcomes in the theory of change were:

- **Improved mental health**
- **Reduced loneliness and isolation**

- **Improved physical health**

These were the outcomes that need to continuously manage. Through analysis of the on-going quantitative indicators, consideration will be given as to how much change has occurred, also whether the theory of change is still relevant.

As the project has evolved to more of a crisis service, we needed to reassess and confirm the outcomes identified were relevant and still held up to the materiality test. Due to the impact of Covid, limited stakeholder engagement and qualitative data collection work was possible. However, after engaging with staff member and some clients, there is confidence that the outcomes are still relevant and hold significant value for the clients.

a) Improved mental health

Many of the referral organisations explained how many of the issues they deal with are related to helping people with their confidence levels, for a variety of reasons they are struggling with their confidence. This in turn causes anxiety and stress for individuals, with covid also having a major impact. Some have caring responsibilities and have become isolated within their communities but have also developed problems with their own mental well-being. As mentioned on the report, improved mental wellbeing for crisis clients has been main outcome for the project this year.

The Community Link Officer and other staff members at Mantell Gwynedd have been a support network for clients over the last 18 months and clients being able to phone up and speak to someone can greatly improve their mental health. In some cases, the staff at Mantell Gwynedd would be the only people clients speak to during the day. Having someone to talk to at a point of crisis has a positive impact and reduces the chance for the clients going into further decline. Therefore, it cannot be emphasised enough the positive impact the project has to improve client's mental well-being. From the data collected on Elemental, ONS 4 anxiety, **83.8%** of clients reported reduced levels of anxiety due to the support given by the project, with a level of change of **24.3%.**

Improve mental health also leads into clients feeling reduced loneliness and isolation.

b) Reduced Loneliness and isolation

The main objectives of the project are to support individuals who have social and emotional needs and to reduce demand on statutory services. Loneliness and isolation can have an impact on many individuals of any age, gender, or other social economic factors. Individuals were asked about their level of social interaction, about feeling part of the community and the impact of Covid-19 on their mental wellbeing.

There were many reasons why people found themselves feeling lonely and isolated and these included caring duties, covid restrictions, physical and mental health conditions, or living in rural areas with limited support network available during a time when it is needed most. In addition, the continued impact of Covid-19 is having on the most vulnerable in society, with some clients still not confidence to venture out and socialise, thus increasing the feeling of loneliness and isolation. Over the 12 months the impact the project has had on reducing loneliness and isolation has varied, due to Covid-19.

Based on the data on elemental, **97%** of individuals questioned felt there was a positive change in feeling less lonely and isolated because of being in regular contact with the community link officer over the phone. Having someone to talk to can have a major impact on those who are feeling lonely and isolated, especially elderly people[3]. This is seen in the data analysis and engagement throughout the period of the pandemic when speaking with the clients.

c) Improved physical health

Many of the individuals referred to this project are living with various acute and chronic health conditions. This includes arthritis, stroke, fibromyalgia, diabetes,

[3] Hwang, T.-J., & Rabheru, K. (2020). Loneliness and social isolation during the COVID-19 pandemic. International Psychogeriatrics, 1217-1220.

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.

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.

Although the overall majority of venues and organisations are now open to the public due to some relaxation in restrictions, many of the activities groups and centres are still closed. Most if not all organisations now do offer plenty of online support for clients, as they change and adapt their approach to be more virtual, thus having the ability to engage with the clients.

As discussed, the majority of the clients are over 65 and many of the originations that support this age group are still limited in what services they are able to offer which can have a negative impact on their physical health due to limited ability to move around.

Of those questioned, pre and post support from the project, there is an average increase in the level of change of **40%** in their physical health, with **57%** of clients experiencing some positive change. An increase from 19% from last year report when analysing the impact on client's physical health during covid. The lifting of shielding requirements being a contributing factor to the increase level of change experience by the clients' year on year.

No change or negative outcomes?

As with the previous report, many clients had experienced no change. Looking at the sample of data, 8.1% of clients experienced no change, which represents 10 individuals. Consideration should be given as to why these individuals don't experience any change, and if inappropriate referrals are being made to the project. In the previous report, these clients were identified as follows, with the continued effects of Covid-19 also a contribution factor this year:

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. This may not be possible at present, however, as we slowly ease through the pandemic, more opportunities for training maybe be available.

b) Crisis clients – those referred who need immediate support, but because of their situation may not experience positive changes; however, the service could prevent things from deteriorating and their needing statutory support. This has been highlighted in the report, some may not have experience significant change, some social value and positive change has being created to improve clients' mental well-being.

c) Continued impact of COVID 19 – This project still receives covid-19 related referrals, on the impact of the pandemic is still felt by those most vulnerable, therefore, the changes experience in the short term may be no to a little change, may be more long-term social impact.

d) Negative outcomes – some negative outcomes were identified this year, 4% of clients felt increased levels of anxiety and reduced physical health. For some reason the project has not benefited them. The period we have been in the pandemic may be a contributing factor. Consideration should be given on why this is the case, what change can the project make to reduce this number.

Value

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. The table below shows the average weighting given to the outcomes, demonstrating that changes in their mental health was the most valuable.

The outcomes were weighted out of 10. As we are still in the covid 19 pandemic, we are using the same values as in last year report as they are still relevant.

Outcome	**Value (out of 10)**
Improved mental health	8.5
Reduced loneliness and isolation	8.0
Improved physical health	5.5

"I just want to say how your help over the past 5 years has been invaluable both to myself and my clients and I know that this is echoed by many of my colleagues working within the Community Mental Health Team and Primary Services alike. There is nothing else, like this service in our locality and I highly recommend that this should continue both now and in the future. I really, do not want to think how this would impact on our services should this service stop for any reason".

(BCUHB Adult Mental Health and Social Care)

CASE STUDY – Person A

During the course of the pandemic, person A has had to follow Government guidelines and self-isolate for long periods at a time. The impact of having to isolate has left Person A feeling depressed, lonely and a sense of losing some independence. In addition, Person A now feels scared to carry on with 'normal' life, feeling uneasy going to the shops and carrying on with daily activities. Also over the last 18 months Person A has lost friends due to Covid, this making Person A feel like they have no one to turn to.

Person A contacted the Community Link Officer during the first national lockdown needing information on how to get food and medication during a time of self-isolation. Person A also looks after their son who has learning difficulties and needed information about being a carer during this time, if any additional support is available. This was for Person A to be able to remain as independence as possible rather than relying on other family and friends.

After a number of phone appointments with the Community Link Officer, Person A was given more information around volunteering opportunities and training, support for people hard of hearing and information about the Ogwen partnership. Other support provided by the Community Link Officer include information on falls prevention, MS, financial and benefit issues, losing sight and community transport.

Outcomes Identified

- Improved mental health, being better able to cope
- Reduced feeling of isolation and loneliness

Being able to keep regular contact with the Community Link Officer and having someone to turn to during trying times has helped Person A cope during the pandemic.

Feedback from Person A

"I can't thank Rhian enough for all the help and support given to me during this year, I would be lost without her"

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, 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 led to positive changes in their lives in the short time that we did this analysis, but we forecast that this will continue to improve over time.

The results in Table 4 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.

Table 4 - Present Value Created per Individual Involved

Stakeholder	Average value for each individual involved
Individuals	£1,519

The overall results in Table 5 highlight the total value created, the total present value (discounted at 3.5%), the net present value, and ultimately the SROI ratio.

Table 5 – SROI Headline Results

Total value created	**£**
Total present value	£254,101
Investment value	£58,048
Net present value (present value minus investment)	£196,053
Social Return on Investment	**£4.38:1**

The result of £4.38:1 indicates that for each £1 of value invested in Community Link, Arfon Social Prescribing Model, a total of £4.38 of value is created.

Conclusion and Recommendations

This report has demonstrated that the Community Link Arfon Social Prescription Model has created over £250,000 of value, and for each £1 invested, £4.38 of value was created;

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

The main reason for the decrease in Social Return on Investment this year compared to the previous year is the impact of Covid-19 on the number of clients supported compared to last year. However, as shown throughout the

report, the service provided by the Community Link Officer has been vital for the mental health of the clients and continues to be throughout the pandemic. Also, further understanding of the importance of the different outcomes helped to ensure a greater understanding of these changes.

However, some recommendations are still given below:

1) Although the **sustainability** of other services is beyond the management of Mantell Gwynedd, one common concern raised by staff and partners was the sustainability of services. The short-term funding meant that the work of the Community Link Officer to have alternatives for clients was becoming increasingly hard. Good partnerships are created which ensure the best outcome for clients, however, when these projects end, time is again spent building up new partnerships.

2) **No change** - focus should be given to looking at why 8.1% of participants said they had experienced no change when they took part in this review. 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 had a 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 were it not 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 to support clients in crisis.

3) **On-going data collection and managing social value.** As the project continues to evolve and change over time, on-going data collection is vital to ensure we are measuring the correct well-defined outcome and therefore managing the social value created by the project. This will help optimise the positive impact and reduce potential negative impact experience by the clients.

CASE STUDY 2

This case study considers four individual cases but all four facing the same problem which had a detrimental impact on daily life and their mental and emotional wellbeing.

Four ladies who were refused the blue badge after they had tried to renew theirs. All the ladies had been with a blue badge for several years due to long term and chronic health conditions such as Parkinson's, Cancer, spine, and hip problems. The ladies are between the ages of 74-86 years old. When referred by their GP or self-referred they were all worried and upset about how they were going to be able to continue to with their daily activities like shopping, attending appointments, groups and meeting with friends and families,

During the telephone interviews they highlighted how the process of obtaining a blue badge that cause them to get upset and worry, thus resulting in higher levels of stress and anxiety.

All four individuals explained how they have been trying their best to keep their independence and not having to rely on others, especially putting additional strain on their close families. Two individuals explained how they have had to ask for additional assistance from their cares / volunteers to help.

Through the support of the ,Community Link Officer three application forms were submitted. . The Community Link Officer explained the importance of how much a blue badge having would greatly benefit the individuals and help them better able to cope with their medical conditions.

All individuals now have their blue badges thanks to the help and support provided by the Community Link Officer.

Feedback from the individuals

"I can't thank you enough"

"I thought my freedom had come to an end"

"Having the blue badge means so much to me, thank you"

"This makes life much easier"