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COMMUNITY LINK SOCIAL IMPACT REPORT 2019-2020

"I had no idea there was so much help available, it has given me peace of mind that if I need help I know where to go for support"

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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 role of social prescription is to use the knowledge of the activities and services offered by the local third sector and then to identify opportunities for people to engage with, in the hope it will reduce their demand on statutory services such as the NHS and Social Services

A full report on the initial two years of this project was published in September 2018, an interim report was then produced in September 2019. This current report will analyse the social impact of the Community Link project in Arfon provided by Mantell Gwynedd between the 1st October 2019 and the 30th September 2020.

It should be noted that COVID -19 had an impact on the service the Community Link Officer was able to provide during this period due to the national lockdown on the 22nd on March 2020 which impacted on clients and particularly the ability for the Community Link Officer to meet face to face with clients. The impact of this service on individuals will be considered, but also the value to other statutory services, especially the health board.

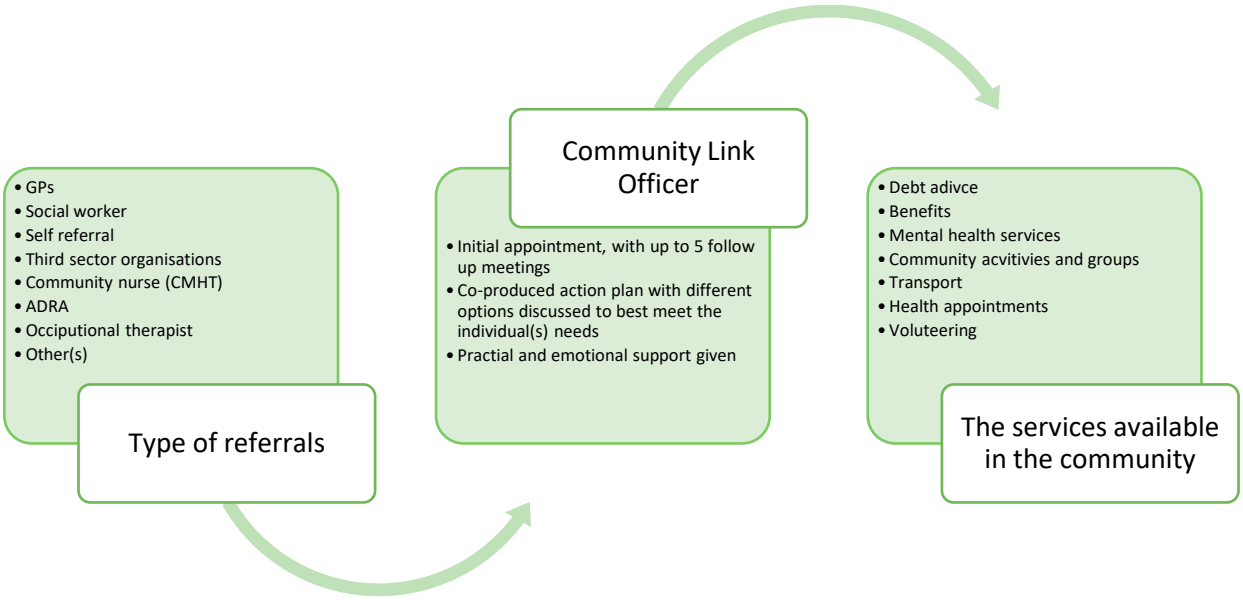
Through engagement with individuals receiving the services as well as referral organisations, and from examination of information and data available, appropriate estimations have been made, supported by secondary evidence.

Eleri Lloyd, Mathew Lewis & Gareth James

Social Value Cymru, Mantell Gwynedd.

November 2020

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. A number 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 £55,695 (£57,000 in 2018-2019) was provided for the 12 months period of analysis, funded through the Primary Care fund from Betsi Cadwaladr University Health Board (BCUHB).

In addition to necessary funding, a good working relationships between GPs, clinical staff, ADRA and the Community Link Officer, along with their willingness to refer individuals is essential towards the success of this project and ensure clients receive the support they need.

Because of the need for health care professionals and other organisations e.g. ADRA, 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 (31 referrals X £39.23). Therefore, total of £1,216	Unit Costs of Health and Social Care 2019 PAGE 120
Adult, health and well-being Services, Social Services	Initial referral – estimated 10 minutes each.	£46 per hour of individual-related work (19 referrals X (£46/6)). Therefore, total of £146	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 9 referrals X (£44/6)). Therefore, total of £66	PSSRU Health and Social Care Costs page 129
Support Workers	Initial referral – estimated 10 minutes each.	£23 per hour for family support worker used (4 referrals X (£23/6)). Therefore, total of £15	PSSRU Health and Social Care Costs page 129

[1] Curtis, L. Burns, A. (2019) Unit Costs of Health and Social Care 2019. PSSRU.

ADRA	Initial referral – estimated 10 minutes each	£8.72 per hour based on current living wage (105 referrals x (8.72/6)) therefore total of £152.60	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 Primary Care fund, BCUHB	£55,695	Strategic management, time, expertise	
NHS	£1,443 in addition to the funding	£1,443 of value for the time taken to refer people to Community Link	
ADRA	£153 in additional financial input	£153 of value for the time taken to refer people to Community Link	
Totals	**£57,291**		**£203 per individual**

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

Outputs 2019-2020

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 2019 – September 2020 there were **316 referrals, 104 referred due to COVID-19**. In total, since the launch of the project in June 2016, **995 individuals have been supported through the programme.** However in 2019 -2020, 11% (34) of referrals are re-referrals and therefore we will consider the value for 282 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	31	10%
Mental Health Team	19	6%
Nurse	1	0.5%
Occupational Therapists	9	3%
Self-referral (card by GP)	106	33.5%
Self-referral by ADRA	104	33%
Support Workers	4	1.26%
Physio	1	0.5%
Other services	7	2.2%

Individuals benefit, on average, from 1–5 sessions, face to face and/or telephone with the Community Link Officer. Contact is very much determined by their needs. The average number of sessions was 3 meetings, so usually 3 hours of 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 was therefore 5 hours.

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.

Impact of Covid-19 on the service provided

Covid-19 had an impact on the service which the Community Link Officer was able to provide. The types of services available to support clients was also considerably different due to Covid-19. The majority of clients supported by the Community Link Officer are those individuals who are lonely and isolated within the community. Covid-19 has unfortunately intensified these circumstances with many people having to shield due to government advice. 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.

The change to the way the services are delivered

Pre Covid-19 most of the appointments with the Community Link Officer were face to face at the client's home or at Mantell Gwynedd offices. Due to the lockdown and additional restrictions there are no face to face appointments at present. All appointments are now via telephone. The Community Link Officer has still spent up to 5 hours of contact time with clients via telephone. It is vital for the clients to have the Community Link Officer there as support and has helped improve the clients' mental health over the lockdown period and beyond. Many clients have seen the Community Link Officer as a befriender during this period, available at the end of a telephone call and able to support virtually.

Shielding

The average age of the client is 70+ years old therefore the majority were told they had to shield during the lockdown. 104 clients were referred by ADRA and had been advised to shield. The knock-on effect of the shielding has resulted in clients having reduced physical health as they were advised not to leave their homes. Those questioned reported reduced physical health during Covid-19. However, clients reported that having the telephone appointment with the Community Link Officer helped their mental health. The support that the Community Link Officer was able to provide was limited compared to the service provided before the lockdown.

The working relationship with ADRA

ADRA (previously known as Cartrefi Cymunedol Gwynedd) was established in 2010 as a social housing organisation and manages over 6,400 homes. It is North Wales' largest social housing provider.

At the outset of the pandemic, Mantell Gwynedd formed the Covid-19 Gwynedd Volunteers Bank. Over 600 individuals signed up to the Bank within the first month and volunteers were signposted and supported into volunteering opportunities across Gwynedd.

Mantell Gwynedd formed a particularly effective partnership with ADRA in order to find ways of supporting vulnerable tenants, particularly those who were shielding. ADRA was particularly concerned about isolated tenants becoming further isolated due to Covid-19 lockdown requirements. Mantell Gwynedd's Community Link Officer was able to take referrals from ADRA and as well as assisting tenants by telephone it was also able to match tenants up with volunteers from the Covid-19 Gwynedd Volunteers Bank. Over 80 volunteers were matched up with shielding tenants.

Only 4 GP referrals were made to the Community Link Officer during the lockdown period which reflects the reduction in face to face GP appointments and the reduction in general of those attending GP surgeries.

"Despite the service being limited by COVID-19 restrictions, I see the service offered by Mantell Gwynedd as essential as there is little on offer for people during the pandemic. People coming through our services are in crisis and socially isolated, being referred to Mantell Gwynedd, even though limited support can be a life line for people, to know they will be linked with someone in the community, who will offer tailored support to them." (Community Mental Health Team)

Outcomes

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:

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

These were the outcomes that need to be continuously managed. 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. The outcomes were analysed pre and during Covid-19 with the virus having an impact on the identified outcomes, and further impact on the client. Any potential negative outcomes will be considered.

a) Reduced Loneliness and isolation

From the beginning, 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, physical and mental health conditions, or living in rural areas with limited transport opportunities.

Based on the recent questionnaire results, **48%** of individuals felt there was a positive change in feeling less lonely and isolated. Over the 12 months the impact the project has had on reducing loneliness and isolation has varied, due to Covid-19. Before the pandemic, clients reported a distance travelled (level of change experienced by the service users, the higher the number, the greater the impact on the individuals) of 49%, therefore the clients felt some change, this is on par with the pervious years of the project. The distance travelled during the pandemic is 77%, this is an indication of quite a lot of change / a lot of change. These figures clearly show that the project has had a positive and strong impact on reducing the levels of loneliness and isolation experience by the clients during the pandemic.

"I was devastated when they refused me to renew my blue badge, it affected my mental well-being. I wanted to be as independent as I can and thank to your help I can still do my own shopping, appointments, visit family independently, I am so grateful"

b) 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. Some have caring responsibilities and have become isolated within their communities but have also developed problems with their own mental well-being.

"I was in a bad place when we met, but now I'm getting there. I know if I need help I can phone you and you will help me through; keeping my depression at bay"

The level of change for improved mental health was consistent over the year, with 57% average distance travelled during and pre COVID. The difference with the mental health is the weighting given by the clients. Pre COVID a weighting of 7.5 and during COVID a weighting of 8.5. Both are scored out of 10. These figures indicated that the service provided by the Community Link Officer mean more to the clients' mental health with a greater value to the individuals. Reducing people's anxiety and depression caused by the pandemic, knowing that the Community Link Officer and the Mantell Gwynedd team are only ever a phone call away.

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, 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.

"I was stuck in the house, unable to go out. The ramp is my lifeline to the community and the outdoors, unable to thank you enough."

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 effects of the lockdown and shielding has had an impact on the level of positive changes experienced by the clients over the 12 months. Of those surveyed, 64% reported positive change to their physical health before the pandemic. However, this is reduced to 19% during COVID and is to be expected. As shown in the report 104 referrals to the project were people having to shield and this will have a knock-on impact on their physical health.

No change or negative outcomes?

As with the previous report, many clients had experienced no change. Looking at the sample of data, 33% of clients experienced no change, which represents 94 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 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.

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.

c) Impact of COVID 19 – the number of people referred to the project due to COVID is 104, not all of them will notice change to their lives as of yet as COVID still has negative impact on all, from lockdowns, to additional restrictions. These figures should reduce over time as the restrictions are lifted and organisations that the Community Link Officer can signpost individuals to become fully operational again.

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 is not 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, for the impact on the individuals both pre COVID and during COVID, then an average of both to give the 12-month overview.

Outcome	Pre COVID-19	During COVID-19	Average of how important is this change out of 10 over the 12 months?
Improved mental health	7.5	8.5	8
Reduced loneliness and isolation	8.0	8.0	8
Improved physical health	6.5	4.5	5.5

Feedback from referrals agents

As part of this analysis, time was spent engaging with referral agents to further understand the impact on clients, but also to develop an understanding about the impact on their services and the impact COVID-19 has had on the referral process.

"I have found Rhian reliable and accessible. We have developed a robust relationship and Rhian has demonstrated excellent communication skills and understanding of client needs. She is warm, friendly and approachable. Rhian has been reliable in sharing information and updates about clients she has been involved with which I can then ensure that this information is entered into the clients clinical notes if they are open to services and into our own documentation.

Psychiatric Liaison is a brief intervention service, so referring to Rhian in Mantell Gwynedd can be fundamental to a client's mental health and recovery. Rhian knows what services are on offer locally and how an individual may be able to access a certain benefit. I know that I can refer individuals to Rhian with confidence that their needs will be met as best as they can be in terms of them being given the tools and information to know what resources are available to them in their recovery".

Community mental health team (BCUHB)

CASE STUDY A

A was advised and given the Community Link card by her GP to contact the project due to concerns about her housing situation and the impact it was having on her physical and mental health. She had been battling cancer and recovering from strokes and falls, which had caused numerous fractures over the last few years.
An appointment was arranged to visit her home. The Community Link Officer was given a tour of the house. The window frames had holes and were in a state of disrepair. Wind was blowing through the gaps and holes. The walls in the house were damp and wet. The front and back door had large gaps letting in cold air. A personal items and clothes had been affected by damp.

A explained when she received her pension, that most of the money was spent on the short fall in paying her rent and trying to heat the house by using the coal fire in the living room. A could only afford to try and heat one room. A explained that she had to limit using the central heating to an hour a day as she had no funds left from her pension. A explained that the house which she had privately rented for many years had been in probate for some years. This was the reason why there had been no maintenance and repairs done to the property.

During the visit she explained that a family member had an annex that is rented out and that this would be available soon. A wanted confirmation she would receive housing benefits if she moved and rented the annex. The Community Link Officer contacted the relevant department for advice on this matter. She was advised to ensure that A filled in an additional 'closely related' form which would state that she is related to the landlady of the annex. Also, to ensure that everything was legal i.e., rent book, insurance etc. We were also advised to have a covering letter explaining the situation when claiming housing benefit.

Referral was made to Age Cymru Gwynedd and Môn to help A to apply for extra financial support, grant application was made for heating oil and a microwave to cook hot meals cheaply. Referral was made to Shelter for information and support regarding her current housing situation. Information regarding support and help available was sent pre pandemic and during pandemic.

Outcomes

The grant application was successful which meant that A had a warm home and was able to have regular hot meals while trying to arrange to move to a new house. The pandemic had an impact on the arrangements of moving to a new house. A response was "at least I have heating and hot meals and I know that I will be moving hopefully in the near future"

A has now moved into her new home which is dry, warm, comfortable and habitable A has also now got family support and companionship. A stated, "I was so isolated in the other house". Now I have family and neighbours that I can talk to while I walk the dogs it's brilliant." A now receives extra financial help to top up her pension which means she can afford basic needs. A has now started reading again, making crafts and using the computer.

A stated **"I had lost all interest and did not realise how low in mood I had become. I could not have done this without your help. I'm so grateful, I feel a lot better, safer and warmer. My health was deteriorating so rapidly, and it was very frightening but now I'm in such a better place". "Thank you".**

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	£1,137

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	£377,963
Investment value	£57,291
Net present value (present value minus investment)	£320,672
Social Return on Investment	**£6.60:1**

The result of £6.60:1 indicates that for each £1 of value invested in Community Link, Arfon Social Prescribing Model, a total of £6.60 of value is created.

Conclusion and Recommendations

This report has demonstrated that the Community Link Arfon Social Prescription Model pilot will create over £370,000 of value, and for each £1 invested, £6.60 of value was created;

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

The main reason for the slight decrease in Social Return On Investment this year compared to the previous year is the impact of Covid-19 on people's physical health, however as shown throughout the report, the service provided by the Community Link Officer has been vital for the mental health of the clients. In addition, more people have used the social prescription service over the last 12 months, with less financial inputs. Also, further understanding of the

importance of the different outcomes helped to ensure a greater understanding of these changes.

However, some recommendations are still provided below:

1) **Data collection** – ensuring we have baseline data and having a mid-review and end review are essential for us to understand if there is any change, but also how much change, and whether there are differences in the needs of different individuals Also to extend this to include other important stakeholders such as wider family members and unpaid carers. When such data is collected over a period of time, the potential to use the 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.

2) Although the **sustainability** of other services is beyond the control 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. Findings from all available project evaluations should be collated to form a case for future commissioning of services and should drive future commissioning practices.

3) **No change** - focus should be given to looking at why 33% 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. In addition, Covid-19 has directly contributed to the level of change experienced by clients over the final 6 months of the year.

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.

4) As we approach a post **Covid-19 recovery period** detailed attention needs to be given to the findings of this report, particularly looking at how Social Prescription has provided the vital signposting tool during this period and how we can now incorporate these practices into Track, Trace and Protect work with a particular focus on the Protect element of this work.

CASE STUDY 2 KNOWN AS 'B'

B was referred to the Community Link Officer by the mental health team for help, advice and support that was available for her to continue with her recovery from a chronic mental health episode.

Before the lockdown B had attended a creative writing course, a book club and an anxiety course. She was finding it extremely difficult not being able to attend her support and activity groups due to the restrictions caused by Covid-19. These were paramount in helping her with her recovery.

A telephone appointment was made with the Community Link Officer and options of help and activities that were available during the pandemic were discussed. B stated that she was afraid that her health would deteriorate if she did not have a support network around her.

Outcome

A referral was made to the Red Cross and a grant was applied for. The funding received was used to purchase a laptop so that B could continue with online health courses, creative courses and support networks. B was referred to the Volunteer Centre re: phone buddy. Regular emails are sent to B with information of online groups, activities and opportunities. B received IT support on how to use online shopping websites and how to attend virtual meetings.

Client B's comments

"The support and information that I have received from you has definitely helped me to focus on my recovery. I have learnt new skills on the laptop by joining new groups and activities. The volunteer who has been calling me every week has been such a help. We are still in contact and once the pandemic is under control and the rules allow us to meet, we are going to start to go for walks together so that I can integrate back into the community, lose weight and keep fit. I'm very grateful for your help"