MANCELL GWYNEDD

Yn cefnogi grwpiau gwirfoddol a chymunedol
Supporting voluntary and community groups

CYSWLLT CYMUNEDOL ARFON
COMMUNITY LINK

GRWPIAU
ORGANISATIONS
CYNGOR
ADVICE
MUDIADAU
CLUBS

Arfon Community Link Social Impact Report October 2021 to January 2023

"Because of your help, I now live comfortably in my new home"

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

Mesur Measure
Effaith Impact
Dysgu Learning
Lles/Iaith Well-being

SOCIAL VALUE CYMRU

Table of Contents

Introduction

Social prescribing is a term used in Wales for many years now, and over the last 10 years there have been many developments in this area. There has been various definitions of social prescription across Wales, with different terminology being used in different regions of Wales. The Welsh School for Social Prescribing Research (WSSPR) and Wales Council for Voluntary Action (WCVA) have a clear definition what social prescription is, and what is means in Wales[1].

> *"Social prescribing aims to empower individuals to recognise their own needs, strengths, personal assets and connect with their own communities to access support which will help to improve their health and well-being…… Social Prescribing can require multiple organisations to work together to ensure a coherent, seamless social prescribing model that meets both local and national population needs." (WSSPR and WCVA)*

Social prescribing aligns with the Wellbeing of Future Generations (Wales) Act 2015 and the Social Services and Well-being (Wales) Act 2014 and the foundations of both pieces of legislation focuses on the individuals within communities having a voice and control over aspects of their own on health and wellbeing[2].

A full report on the initial four years of this project was published in September 2018, an interim report was then produced in September 2019, 2020, and 2021. To read these reports, please click here.

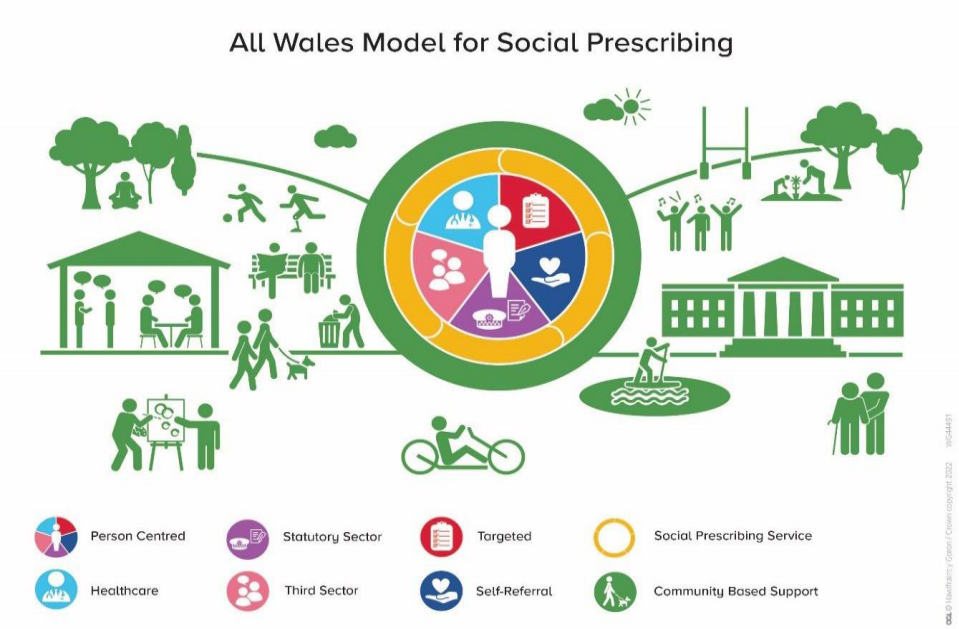
This current report will analyse the social impact of the Community Link project in Arfon provided by Mantell Gwynedd between the 1st of October 2021 and January 31st, 2023. Through engagement with individuals receiving the services and referral organisations, and from examination of information and data

[1] Wallace, C., Davies, M., Elliott, M., Llewellyn, M., Randall, H., Owens, J., Phillips, J., Teichner, L., Sullivan, S., Hannah, V., Jenkins, B., Jesurasa, A., (2021) Understanding Social prescribing in Wales: A Mixed Methods Study. Wales School for Social Prescribing Research (WSSPR), University of South Wales, PRIME Centre Wales, Data Cymru, Public Health Wales.
[2] Bozo Lugonja: Social Prescribing research briefing (2021)

available, appropriate estimations have been made, supported by secondary evidence.

All Wales Social prescribing model – a national framework

A proposed 'person centred' model of social prescribing for Wales by Welsh Government is currently in consultation in 2022 for a national framework for social prescribing in Wales. The framework aims to have standards, guidance and advice for all professionals working with people to ensure the best access to support within communities that will help people to take back control over their own well-being. The diagram below demonstrates the person-centred approach and the various referral routes for support.



National framework for social prescribing: Proposed 'person centred' model[3]

The 'Referral Pathway' of the model is the route of which the individual is connected to the 'social prescribing' service they need. There are 5 proposed routes or referral pathway;

1. **Self-referral** – for people who realise they need help or support and know how to contact a social prescribing service.

[3] Welsh Government consultation document (2022): National framework for social prescribing (number: WG44988)

2. **Statutory sector** – someone who works in the statutory sector sees someone who might be isolated and refers them to a social prescribing service
3. **Healthcare referral** – a healthcare professional identifies that a patient could use non-medical support or help and refers them to a social prescribing service.
4. **Third sector referral –** when someone works in a charity, voluntary or non-profit sector refers a person who they identifies as needing further support
5. **Targeted referral –** this is for people who have specific needs or conditions and a 'social prescribing service offers support to avoid the problem from deteriorating.

The Social Prescriber 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. The Community Link Officer at Mantell Gwynedd identifies the needs of the individual referred and together will agree on an action plan and then activities and services are offered within the community. 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.

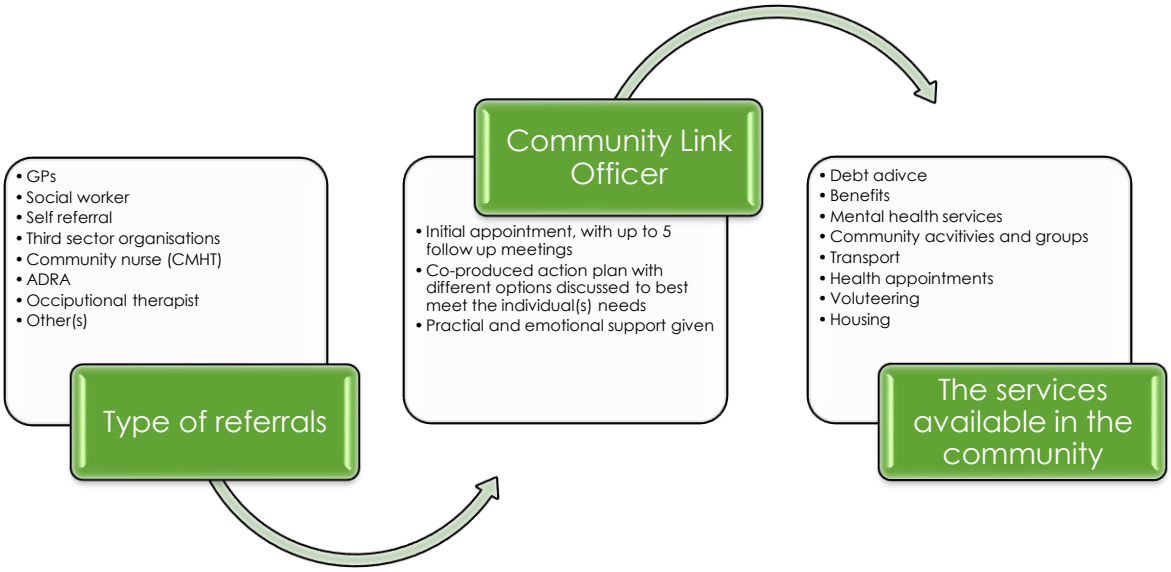
The project already has many of the referral paths as identified in the framework for Wales (please see figure 1). The majority of the referrals are mostly a healthcare referral pathway or self-referral pathway, with 72% of referrals of the referral this year coming either local healthcare professionals or self-referral (please see table 3). However, there is a percentage of referrals from statutory services and other third sector organisations also. The number of self-referrals to the project has been steadily increasing over the last few years as more people become aware of the project. In some cases, the word of mouth of past individuals who have been supported by the Link Officer will encourage others to contact the project and get access to the support they need without having to visit a healthcare professional first, and this also contributes to a reduce demand on statutory services.

The framework identifies key areas of support that the social prescribing service should offer. These include:

1. **Relationship building** – helping them to build trust and relationships with services and within the community
2. **Directing people to local activities or groups (signposting)** – for people who are comfortable joining in their local community.
3. **Direct support** – when signposting is not enough, the social prescriber will work with the person directly to help connect them with activities or clubs in their community and take those first steps.
4. **Community development** – the 'social prescriber' will work with the local community to help develop activities and programmes to suit the needs of the clients they support and build on community strengths.
5. **Feedback** – give feedback to those who referred the individual to the service.

The Arfon Community Link project was established in 2016 to 'direct and advice people of services available in the community and signpost. However, the project has evolved over time and has had to adapt the service when needed due to the changing needs within the community and in response to the pandemic. The social prescriber offers much emotional support to the individuals and has had to deal with many in crisis.

Figure 1 - Process of Referral



Impact of Covid-19 on the service

Over the last 12 months there has been a reduced impact on the service created by Covid-19 compared to the past two years of reporting. For this analysis there were no Covid-19 specific referrals to the project. Covid-19 referrals are classed as those individuals who contracted the virus or had to isolate because someone from the same household had Covid-19. However, the ripple effect of the pandemic can still be seen in the community with a rise of individuals needing mental health support from the project since the outbreak of Covid-19.

The continued support provided during the past 16 months has been key for some clients' mental wellbeing, helping with reducing the feeling of isolation and loneliness, reducing anxiety, and helping alleviate stress. The report will analyse and discuss the positive change or avoided deterioration in mental health impact the project has created for the individuals.

The World Health Organisation have noted that access to mental health services have improved slightly at the end of 2021, however, more care and support is needed,

"By the end of 2021, the situation had somewhat improved but today too many people remain unable to get the care and support they need for both pre-existing and newly developed mental health conditions" World Health Organisation[4].

The role of the Community Link Officer in supporting people with low level mental health concerns is vital for the individuals they support through the project and taking pressure off the statutory services.

Clients supported by the Community Link Officer are those individuals who are lonely and isolated within communities. 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, for example, some organisations of which the link officer refers clients to still primarily offer support over the phone or virtually rather than face to face.

Project Inputs

This service is free to those that receive it; however, some non-financial inputs are also necessary to ensure any changes. Their willingness to engage 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.

The financial input is managed by Mantell Gwynedd. A financial input of £79,070 was provided for the 16 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

[4] World Health Organization. (2022). COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide. *Retrieved from World Health Organization: https://www. who. int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide*.

a typical GP appointment of £39.23[5] 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 (38 referrals X £39.23). Therefore, total of £1,490.74	PSSRU Health and Social Care Costs page 111
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 122
Occupational Therapists	Initial referral – estimated 10 minutes each.	£47 per hour of local authority operated occupational therapists 9 referrals X (£47/6)). Therefore, total of £70.50	PSSRU Health and Social Care Costs page 122

[5] https://kar.kent.ac.uk/92342/25/Unit%20Costs%20Report%202021%20-%20Final%20version%20for%20publication%20%28AMENDED2%29.pdf

Other / 3rd sector services	Initial referral – estimated 10 minutes each	£9.50 per hour based on current living wage (38 referrals x (9.50/6)) therefore total of £60	Gov.co.uk [6]

Table 2 – Total Monetised Inputs for Social Prescribing

Stakeholder	Financial input	Non-financial input	Cost per individual
Individuals	N/A	Willingness to take part and take action identified with the Community Link Officer	
Mantell Gwynedd – manage funding by BCUHB	£79,070	Strategic management, time, expertise	
NHS	£1,707 in additional referral cost	£1,707 of value for the time taken to refer people to the Community Link	
Other routes / 3rd sector services	£60	Cost to refer 38 individuals to the project through various services	

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

Totals	**£80,837**	**£342 per individual**

Outputs

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 16-month period October 2021 – January 2023 there were **236 referrals** based on data given on the Elemental database**.** In total, since the launch of the project in June 2016, **1,374 individuals** have been supported through the programme. To avoid overclaiming the social value created by the project from October 2021 to January 2023, **142 (60%)** of individuals supported on the project will be included in the value map. This in line with the pervious years reporting with a similar percentage of individuals included in the value map. Thus, giving a good comparison on a year-on-year basis.

Table 3 below shows a breakdown of how the 236 individuals were referred to the project.

Table 3 – Source of Referral

Source of Referral	Number of Individual Referred	Percentage of Referrals
GP	38	16%
Adult, health and well-being Services	19	8%
Occupational Therapists	9	4%
Self-referral	107	45%
Re-referrals	15	6%
3rd sector organisations	21	9%
Other services	27	12%

Individuals benefit, on average, from 1–5 sessions via telephone, virtually or face to face with the Community Link Officer. Contact is very much determined by their needs. The average number of sessions this year 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.

38 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 since 2020. However, the number of GP referrals have increased compared to last year and this may be due to the Covid related restrictions being lifted, or that the individuals feel more comfortable / less worried or anxious visiting their GP compared to last year before then being referred to the Community Link Officer.

Feedback from referral agents

Occupational Therapist Advanced Practitioner

"In Rhian's role in Mantell Gwynedd, she has provided a positive link between the Psychiatric Liaison Service in Ysbyty (through Occupational Therapy) and I have made many referrals to Rhian for patients with complex mental health and physical health needs. I have also observed her presence in the Welsh Emergency Department Frequent Attenders Network which has enabled effective sharing of information with a wide range of professionals for the benefit of patients who come through the Emergency Department with complex needs and multiple visits. Through this she has followed individuals up in the community and provided a crucial service to people who were likely to not have their needs met otherwise. Rhian's role has reduced the amount of people being readmitted to our service and the cost to the public purse. Support through Rhian and Mantell Gwynedd is accessible and proactive.

I am now in a new role working into GP practices in the Arfon area and I have already met with Rhian to discuss how we can continue to work together effectively in meeting the needs of local people with low to moderate mental health needs. Feedback from Rhian about the needs to the local community is important shaping services appropriately."

Community Mental Health Team

"The service has significantly helped many of my clients improve their mental and physical wellbeing. I remember one client mentioning Rhian by name. Really appreciated support given, thought Rhian were approachable and friendly, felt service offered was excellent and felt much better afterwards."

Outcomes

All the data for the outcomes is collected and analysed through the Elemental platform. The Elemental software helps organisations to enhance the impact of their social prescribing programmes via their digital social prescribing products and data collection services / database [7]. Using the 'heath impact report' database, we can track the progress and level of change clients have or are going to experience throughout the year, using ONS Q1 for 23 & 4 data collection surveys. The questions are set to measure peoples well-being for life satisfaction, worthiness, happiness, and anxiety, and is a part of the Measuring National Well-being developed in 2011[8]. 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 be more well-defined outcomes to better understand and measure the social impact created. Therefore, for this assessment we also collected quantitative data through Survey Monkey to ensure we have a strong sample size and enough data in relation to the outcomes identified.

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. As the project has evolved over time, we needed to reassess and

[7] https://www.gov.uk/g-cloud/services/209867697068843
[8] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/methodologies/surveysusingthe4officefornationalstatisticspersonalwellbeingquestions

confirm the outcomes identified were relevant and still held up to the materiality test. With continuous engagement throughout the year with staff member and some clients, there is confidence that the outcomes are still relevant and hold significant value for the clients.

a) Reduced Loneliness and isolation

The primary objective of the project since its establishment in 2016 is 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 on their mental wellbeing.

There were many reasons why people found themselves feeling lonely and isolated and these included caring duties, the continues covid impact on services, physical and mental health conditions, or living in rural areas with limited support network available during a time when it is needed most.

The ripple effect of the pandemic can still be seen with the most vulnerable or the older population in society, they are still experiencing high level of social isolation in 2022 according to (Kotwal, 2022) [9] .This is where service and in particular the Community Link Officer are still very valuable to the clients, and this can be seen in the data collected for this analysis. Based on the data on collected, **100%** of individuals questioned felt there was a positive change in feeling less lonely and isolated because of being in contact with the Community Link Officer over the phone or knowing that the Link Officer is there when they need someone to talk to, thus reducing the feeling of isolation.

[9] Kotwal, A. A. (2022). Persistent loneliness due to COVID-19 over 18 months of the pandemic: a prospective cohort study. *Journal of the American Geriatrics Society*.

The level of change experience by the individuals surveyed is **63%**. This is equivalent to quite a lot of change experienced by the sample size, showing the positive impact of engaging with the Community Link Officer in helping reduced the isolation and loneliness felt by the clients.

"All the help and changes would not have happened without you"

"You listened and made me reflect, what happened was out of my control due to the pandemic rules"

---

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 which many struggle, this in turn causes anxiety and stress for individuals. Some clients have caring responsibilities and have become isolated within their communities but have also developed problems with their own mental well-being. This year the clients who are referred to the project have had a tough time mentally, with many still having some anxiety or feeling worried about returning to 'normal' as the country comes out of the pandemic.

"You gave me advice and information/facts before I made a big financial mistake"

Also, with the cost-of-living crises, and the uncertainty with what the future hold, this is having an impact on the individual's mental well-being. Many of the individuals on the project are struggling with their finances and don't know where to go or who to speak with, especially with the energy crises facing the county from October onwards and the continued impact of higher inflation. The

Community Link Officer helps reassure the clients of the support available to get them back on track.

"You listened and got me the support I needed and more"

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, **90.3%** of clients reported reduced levels of anxiety due to the support given by the project, with a level of change of **21%** or a reduction in anxiety levels of 2.08 on a 10-point scale.

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.

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 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 who answered the Survey Monkey questionnaire, there is a level of change of **46%** in their physical health, with **40%** of clients surveyed experiencing some positive change.

No change or negative outcomes?

As with the previous report, some clients had experienced no change. Looking at the sample of data, **5%** of clients experienced no change (down from **8.1%** last year), which represents 5 individuals. Consideration should be given as to why these individuals do not experience any change, and if inappropriate referrals are being made to the project. In the previous report, these clients were identified as follows:

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 may 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 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) Negative outcomes – some negative outcomes were identified this year, 5% of clients felt increased levels of anxiety. 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 is changed in people's lives, but also it 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. 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	8.0
Reduced loneliness and isolation	8.5
Improved physical health	6.5

Case Study – Self-Referral via advice from GP (individual referred to as T)

T had received an eviction notice as the landlord of her current home was selling the house. T had then seen a house on Facebook and was in a panic as she was going to be homeless and most private landlords do not accept pets.

T then went on a search for a new house on social media and found one on Facebook. The supposed new landlord seen on Facebook worked away and wanted her to send the deposit of £600 to secure the house and then he would send the keys and tenant agreement. Community Link Officer (CLO) explained this is not usual practice and that before sending a deposit they would need to check if this person was legitimate. CLO explained that there are agencies that can help, support, and advice and asked them to not rush into anything until all options had been explored. T was reminded they have nearly 2 months before the eviction notice has to be adhered to.

T had calmed down and agreed that they would wait until CLO made further inquiries and that she could refer them to Shelter for help and support. CLO then contacted rent Smart Wales and discussed the above and, completed the following tasks on her behalf:

- Checks made regarding current home if registered re eviction notice legal. The present home is registered and legit.
- Checks were made on a new possible home - home registered to an estate agency, and they were responsible for the accommodation.
- Phoned the estate agent and left a message to contact T ASAP

The CLO contacted T again and updated her on the situation, email was sent regarding the Smart Wales link and guidance on how to check all landlords and accommodations. Name and contact details of Estate Agent, Shelter, Digartref, Housing Options, and Smart Wales sent on to her.

Community Link Officer then updated T again regarding the situation, who was so grateful and in her words:

“I was ready to send the money, I was so frightened of being homeless that I wasn’t thinking straight. After our talk you made me realise, I needed to step back, think, and get advice and support from the experts I’m so thankful to you I would have lost £600 and would have been even in a worse situation - no home no money. Now I have had help to fill in the correct forms and I’m receiving support to ensure I do not become homeless. 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 based on current data.

Table 4 - Present Value Created per Individual Involved

Stakeholder	Average value for each individual involved
Individuals	£1,540

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	£444,474
Investment value	£80.839
Net present value (present value minus investment)	£363,637
Social Return on Investment	**£5.50:1**

The result of £5.50:1 indicates that for each £1 of value invested in Community Link, Arfon Social Prescribing Model, a total of £5.50 of value is created.

Conclusion and Recommendations

This report has demonstrated that the Community Link Arfon Social Prescription Model has created over £360,000 of value, and for each £1 invested, £5.50 of value was created;

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

As the proposed Social Prescribing Framework in Wales demonstrates, there needs to be a clear path for people to receive support within the community for non-clinical needs. The Community Link Project has been running since 2016 and has established a clear pathway for many to receive such support with referrals coming from healthcare providers, statutory services, other third sector organisations and also an increase in self-referrals year on year.

This report has shown the positive impact the Arfon project is having on those who need the support, especially those who are at a point of crisis. Many explained how the service had helped them to feel less isolated and reduce their anxieties about engaging with services within the community. For some, the practical support offered by the Social Prescriber helped them to dilute the crisis and allowed them to start taking some positive steps towards improving their well-being, but most importantly perhaps allowing them to identify how they can take back control of their own health and well-being.

The cost-of-living crisis continues throughout the UK into 2023, and the demand of the service is forecasted to increase especially with those needing mental health support. Already there is an increase in referrals where there is great concern about the cost of living, housing concerns, and benefit concerns that is having a detrimental effect on people's stress and anxieties and therefore the importance of such service and a clear pathway is clear. .

However, some recommendations are given below in order to ensure greater social value:

1) The report has demonstrated the need for the service and also that having the service based within the local voluntary council has ensured a clear pathway into the service, but also a clear pathway back into community services. The service is currently available in Arfon but by rolling the service out across the county we could see an increase in social value.
2) In previous reports, the sustainability of services within the community was of concern. Many projects were short term which made it difficult for the social prescriber to refer the individual to appropriate services and was a barrier for change. There has been some change here now with more services resuming after the pandemic, however, many are still short-term projects and therefore much of the social prescriber's time is given to research what is available locally. Good partnership working is already happening, and this could continue to grow to ensure further collaborations and clear pathways.

3) **No change** – The data demonstrated that a small percentage had experienced no change as a result of the intervention. As there wasn't data available for all participants a higher percentage of those experiencing no change was included to avoid over-claiming. 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.

4) **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.

In previous studies, the cost reallocation for other stakeholders was also included. Over the last couple of years, the patterns of using local GPs and ED departments for non-clinical reasons did change due to the pandemic and therefore has not been measured. It is clear that some of these patterns has started again and the social prescriber attends regular meetings at Ysbyty Gwynedd to discuss support for frequent attenders at the ED department. Resources should again be allocated then to understand and measure the impact on other material stakeholders in 2022-2023 in order to understand the wider impact of the project.

CASE STUDY 2 - (Individual referred as W)

W arrived in Wales end of January 2020, a couple of months before the first lockdown. W had decided to sell her home and move back to a very rural area in Wales to help care for her elderly father. W explained he was the only family member she had left. W's plan was to find part-time work and spend quality time with her dad who was elderly and with multiple health issues and they were afraid for their safety and well-being.

Afraid of covid and the effect it could have on her and her father, W used the money from the sale of her home as her daily income as no work was available. Her father's health had deteriorated, and they were unable to get specialist help for her father during the pandemic all his appointments were postponed/canceled. The two decided to realise equity from W's father's house to pay for private medical advice and care in England.

After a year her father, in the end, died in the hospital on his own due to lockdown rules. This has had a detrimental impact on W's mental health that she was unable to be with her father at the end of his life. Struggling with her father's death and the way he died in pain on his own, she now has to pay the equity back on the house or she loses the family home in the next 6 months, W explained she feels lonely and isolated and is desperate to find work to pay back the equity on the house.

CLO discussed options and support available.

- Referral made to support mental health and finding work- contact started
- Information regarding support in the community emailed
- Contact made with well-being hub
- Information on Outdoor activities started attending walking group

CLO contacted W for an update, W stated she felt that the support she was getting is helping her, W has filled in application forms for work and is crossing her fingers.

W explained **"I felt so guilty I blamed myself that my father was on his own when he died, but now I know it was out of my hands and I did everything in my power to be with my father to care for and support him until the end. You and others made me realise that I should not blame myself."**