Mantell Gwynedd

Cyswllt Cymunedol Arfon Community Link

# Arfon Community Link Social Impact Forecast Report 2025/2026

> "Rhian made a lot of difference and helped me sort everything out."

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

SOCIAL VALUE CYMRU

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## Trosolwg mewn niferoedd / Overview in numbers

- **2,036 - Nifer o'r cleientiaid sydd wedi cael eu cefnogi gan y prosiect ers 2016** / Number of clients who have been supported by the project since 2016
- **220 - Nifer o'r cleientiaid sydd wedi cael eu cefnogi yn ystod y flwyddyn** / Number of clients who have been supported during the year

## Ymgysylltu â Rhanddeiliaid a data / Stakeholder Engagement and data

- **220 - Nifer o'r cleientiaid sydd wedi cael eu cefnogi yn ystod 2025** / Number of clients who have been supported
- **60 (maint sampl o 27%) o'r cleientiaid gyda sgôr cychwyn a sgôr gorffen** / 60 ( 27% sample size) of clients with a start score and a finish score

**Adenillion Cymdeithasol Ar Fuddsoddiad**

Forecast Social Return On Investment (SROI)


## Deilliannau / Outcomes

- **Mae 78% o'r cleientiaid a gefnogwyd wedi teimlo gwelliant yn eu hiechyd meddwl** / **78%** of clients supported have felt an improvement in their mental health
- **Mae 94% o'r cleientiaid a gefnogir bellach yn teimlo'n llai ynysig ac unig** / **94%** of the clients supported now feel less isolated and lonely
- **Mae 84% o'r cleientiaid yn teimlo bod eu hiechyd corfforol wedi gwella** / **84%** of clients feel their physical health has improved

## Llwybr cyfeirio / Referral pathway

- **101 Hunan-atgyfeiriadau** / Self-referrals
- **29 o atgyfeiriadau gan feddygon teulu** / GP referrals
- **11 o atgyfeiriadau gan fudiadau 3ydd sector** / referrals from 3rd sector organisations
- **88 o atgyfeiriadau gan wasanaethau eraill y GIG** / referrals from the other NHS services

## Executive Summary

The Arfon Community Link project continues to demonstrate strong and consistent impact across Arfon, supporting 220 individuals in 2025–2026 and delivering an SROI of **£4.43 for every £1 invested**. Demand for the service remains high, driven by the ongoing cost-of-living crisis, rising levels of loneliness, and increasing complexity of client needs.

Through personalised support, thorough case preparation, and effective signposting, the Community Link Officer (CLO) delivers significant improvements in clients' well-being. The evidence shows that **94%** of clients felt less isolated, **72%** reported improved mental well-being, and **84%** experienced improved physical health. These outcomes are closely aligned with the National Framework for Social Prescribing, the new Welsh Government Mental Health and Wellbeing Strategy 2025 – 2035 and the Well-being of Future Generations (Wales) Act.

The project also contributes to reducing pressure on statutory services by supporting individuals with non-clinical needs, enabling more efficient use of GP and NHS resources. Continued investment will allow the project to meet growing demand, reduce the current waiting list, and expand reach into neighbouring areas where need is increasing.

## 1.0 Introduction

The Arfon Community Link project began in 2016 to help people find and access local services in their community. Over the years, the project has grown and changed as people's needs have changed. Today, the Community Link Officer (CLO) not only guides people to the right support but also provides emotional help, often supporting individuals through very difficult situations.

During the past year, the ongoing cost-of-living crisis has continued to put pressure on people's finances and well-being. Many individuals have turned to the project for extra help because these challenges are affecting their mental health, physical health, and leaving many feeling lonely or isolated.

This report looks at the difference the Arfon Community Link project has made between 1st April 2025 and 31st March 2026. It is based on conversations with people who used the service, feedback from organisations who refer clients, and available data. The final two months of the year are forecasted using the best available evidence.

The project has been independently evaluated every year since 2016, and all previous reports show consistent positive results. Over the past seven years, the project has helped reduce loneliness, improve mental well-being, and support people to improve their physical health. This report continues to assess these important outcomes.

# 2.0 Audience, Scope and Purpose

## 2.1 Purpose and scope

The purpose of the analysis is to provide valuable insights into the changes experienced by key stakeholder groups. This report looks specifically at the outcomes and their value for Arfon Community Link main stakeholders, the clients.

This report aims to understand the experience of the stakeholders and establish the following:

- The views of the key stakeholders involved in the projects including clients and referral agents / partners
- To give value to the project and to answer the question: 'Does the Arfon Community Link' project create a positive Social Return On Investment (SROI)for the community?'
- To see what changes to the projects can be introduced to provide more outcomes for their stakeholders to maximise positive impact.

## 2.2 Audience

This report has been prepared for both internal and external audiences. For internal stakeholders, the analysis aims to provide a thorough understanding of the changes created through the activities of the project. This includes assessing both positive and negative changes, as well as intended and unintended results. By gaining insights into these changes, decision-makers at the management level can make more informed decisions and improve the value created by the projects.

For external audiences, the aim is to effectively communicate the impact of the funding to funders and commissioners to see how positive outcomes can be enhanced and any negative outcomes mitigated. Ensuring the involvement of all stakeholders allows a clear understanding of the changes and allows the needs of local communities to be aligned with strategic decision-making.

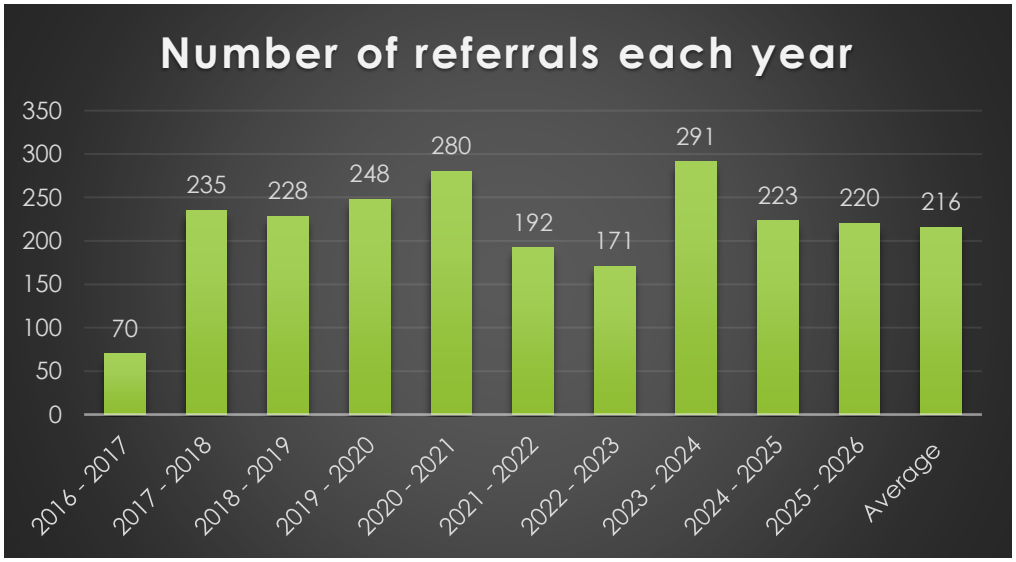
# 3.0 Background and identifying the need for the project

## 3.1 The demand for the Arfon Community Link Project

Since the launch of the project in June 2016, **2,037 individuals** have been supported, with an average of 216 referrals per year (up to end of February 2026) and a total referral for 2025/2026 of 220, another demanding year for the project.

The graph below shows there is continuous and steady demand and need for the Arfon Community Link Project. The CLO now also receives referrals from Dwyfor & Meirionnydd. The project has continued to evolve and has had to adapt the service when needed due to the changing needs within the community and the people who receive the support.

In 2025 - 2026, the project still continues to be well-placed to support many referrals with different complex needs and cases. The CLO has built good working relationships with many third and public sector organisations and is able to offer support, guidance, and advice. It can effectively signpost clients to the relevant organisation based on their needs in an efficient and timely manner.



## 3.2 The Social Prescribing landscape in Wales

The National Framework for Social Prescribing (NFfSP) was launched in December 2023 in Wales. Throughout the last decade social prescribing has seen many different understandings of definitions, terminologies, and standards. However, there is now one accepted definition of social prescribing across Wales:

> "Social prescribing is an umbrella term that describes a person-centred approach to connecting people to local community assets. Community assets include community groups, interventions, and services which could be delivered online or in person, as well as buildings, land, or even a person within a community." (NFfSP, P3[1])
>
> …Social prescribing has seen a period of growth and development over the last decade. However, within Wales, as in other countries, there has been a lack of standardisation and consistency both in the terminology associated with social prescribing and in the model adopted. This has resulted in confusion on the benefits it can offer amongst both the public and the workforce who deliver or encounter social prescribing. (NFfSP, P21[2]).

There are several key areas in the National Framework of Social Prescribing that the Arfon Community Link project has already worked on since the inception of the project and are aligned with the core objectives of the NFfSP (please see Figure 1 below). The CLO works closely with GPs and clinical staff to explore alternative ways of helping individuals within the community, particularly those who are visiting healthcare professionals more often than average with non-clinical needs, increasing the shared understanding of all parties involved. The CLO 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 individuals become more engaged with services within their communities, reduced demand for statutory services such as the NHS and social services can be identified. Additionally, another core objective of the framework is to monitor, evaluate, and improve outcomes

[1] national-framework-for-social-prescribing, page 3, Welsh Government,(2023)(www.gov.wales)
[2] national-framework-for-social-prescribing, page 21, Welsh Government,(2023)(www.gov.wales)

Figure 1 - The Core Objectives


(National Framework for Social Prescribing, Page 22[3])

All three outcomes that have been evaluated by the project since 2016, are also already aligned with, and meet the long-term goals set by the NFfSP (please see figure 2 below). Further information and evaluation of the 3 outcomes will be discussed and analysed in more detail in the outcomes section of the report.

*Figure 2 - 5 Social Prescribing Long-Term Outcomes*

| Social Prescribing Long-term Outcomes | |
|---|---|
| 1. | Improved population mental wellbeing and reduction in overall prevalence and inequalities within mental ill health |
| 2. | Improved population physical wellbeing and reduction in overall prevalence and inequalities within physical ill health |
| 3. | Improved population social wellbeing and reduction in overall prevalence and inequalities within poor social wellbeing, loneliness and isolation |
| 4. | A system impact on the wider determinants of health |
| 5. | Improved community wellbeing |

(National Framework for Social Prescribing, Page 15[4])

The project already has many of the referral paths identified in the framework for Wales (please see Figures 3 & 4 below). The majority of the referrals are mostly a healthcare referral pathway or self-referral pathway. The number of self-referrals to the project has been steadily increasing over the last few years as more people

[3] national-framework-for-social-prescribing, page 22, Welsh Government,(2023)(www.gov.wales)
[4] national-framework-for-social-prescribing, page 15, Welsh Government,(2023)(www.gov.wales)

became aware of the project through various communication channels, and the need for the project has increased year on year, either through a card given by a GP or a direct self-referral. In addition, there is a percentage of referrals from third-sector organisations also.

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 reduced demand for statutory services. The Link officer has developed a reputation of been able to support clients and a quick timeframe over the years, and this can be a lifeline to the clients when they feel they are in crisis.

The CLO produces an action plan based on the client's needs, then refers, and signposts the clients to other community assets, while also monitoring and reporting on the progress of the clients through the Elemental platform.

*Figure 3 - Process of Referral for the Arfon project*

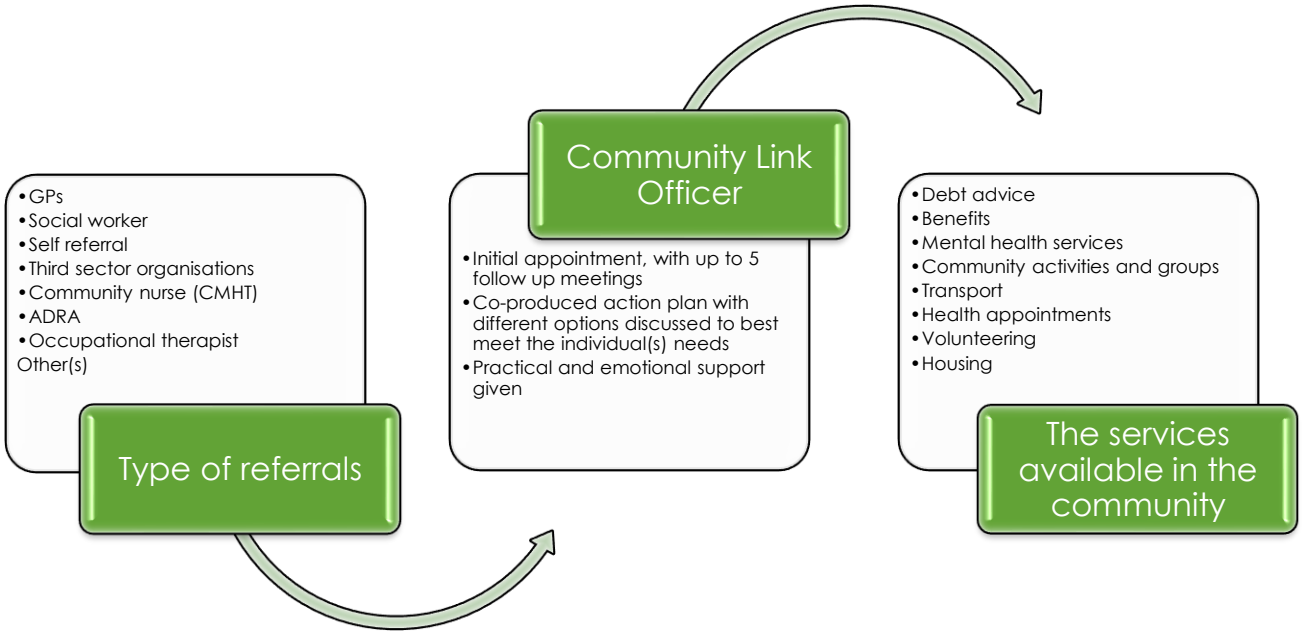
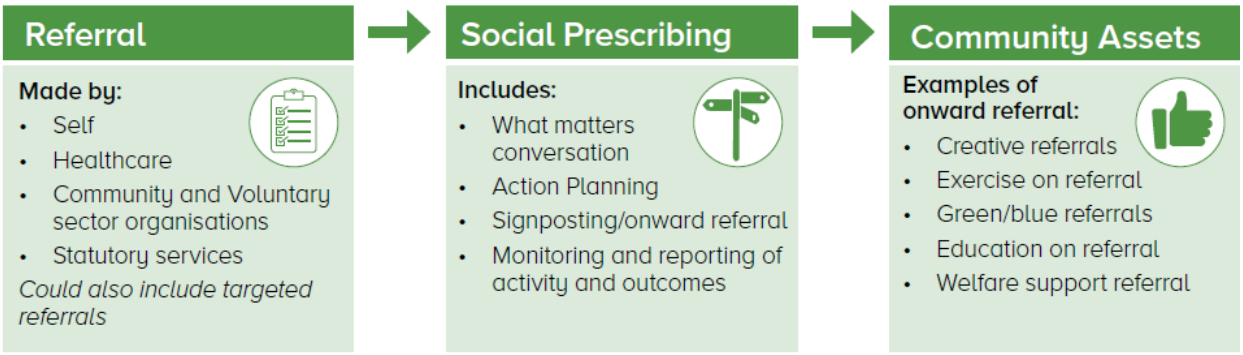


*Figure 4 - The Social Prescribing Referral Pathway*




(National Framework for Social Prescribing, Page 17[5])

## 3.3 Welsh Government Mental Health and Wellbeing Strategy 2025 – 2035.

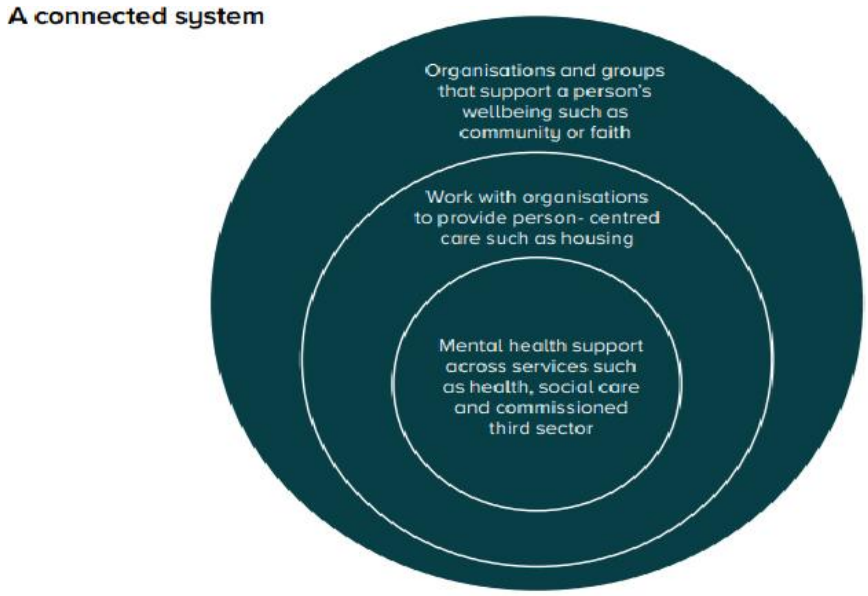
**What is the new Welsh Government Mental Health and Wellbeing Strategy?**

*The Mental Health and Wellbeing Strategy 2025–2035 sets out a ten-year vision for Wales in which people are supported to maintain good mental health, have equitable access to help, and live free from stigma. It responds to rising pressures linked to the pandemic and the cost-of-living crisis, recognising that mental health is shaped by broader social factors such as housing, finances, education, and community connections.*

*The strategy emphasises prevention and early intervention, aiming to ensure people receive support earlier and more easily—often without needing a GP referral—through improved access, same-day support where possible, and better integration of services across health, social care, and the voluntary sector.*[6]

[5] national-framework-for-social-prescribing, page 17, Welsh Government,(2023)(www.gov.wales)
[6] https://www.gov.wales/sites/default/files/publications/2025-04/easy/mental-health-and-wellbeing-strategy-2025-2035.pdf

The Arfon Community Link project also aligns well with the new Welsh Government Mental Health and Wellbeing Strategy 2025 – 2035. The strategy places an importance on **'Taking action to protect and promote good mental health and wellbeing'**[7] and having a connected support system for people to be able to cope and deal with their problems. By signposting clients and collaborating with relevant organisation to support their needs, the CLO is able to support the clients in a holistic way and helps take action to promote good mental health and wellbeing, already undertaking the work the strategy is hoping to implement. Over the course of the past decade, Arfon Community Link has a good track record of supporting clients' mental health, especially during the pandemic and the current cost-of-living crisis, and the evidence for this can be seen in the pervious evaluations of the project.




Additionally, the project also aligns with the preventive element of the strategy. In recent years many of the clients have been referred to the project through the self-referral pathway through either word of mouth or the Mantell Gwynedd website, therefore reducing the need for clients to go through their GP or other NHS departments.

[7] https://www.gov.wales/sites/default/files/publications/2025-04/mental-health-and-wellbeing-strategy-2025-to-2035.pdf (p28)

## 4.0 Social Return on Investment (SROI) Framework

By explicitly asking those stakeholders with the greatest experience of an activity, SROI can quantify and ultimately monetise impacts so they can be compared to the costs of producing them. This does not mean that SROI can generate an 'actual' value of change, but by monetising the value of stakeholder outcomes from a range of sources, it can provide an evaluation of projects that change the way value is accounted for – one that considers economic, social, and environmental impacts. The Institute for Social Value (2014) (formally Social Value UK) [8] states:

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

Based on eight principles, SROI explicitly uses the experiences of those who have or will experience changes in their lives as the basis for evaluative or forecasted analysis. Figure 5 outlines the Principles of Social Value.

Figure 5 - The Principles of Social Value[9]


The guiding Principles ensure that *how* value is accounted for remains paramount. To ensure a consistent approach is used, chains of change are constructed for each material stakeholder explaining the cause-and-effect relationships that ultimately create measurable outcomes. These chains of change create the overall Value Map (attached separately as Appendix 1), and these stories of change are equally as important as the result of analysis. SROI is best thought of as a story of change with both quantitative and qualitative evidence attached to it. Figure 6 summarises the different elements for each chain of

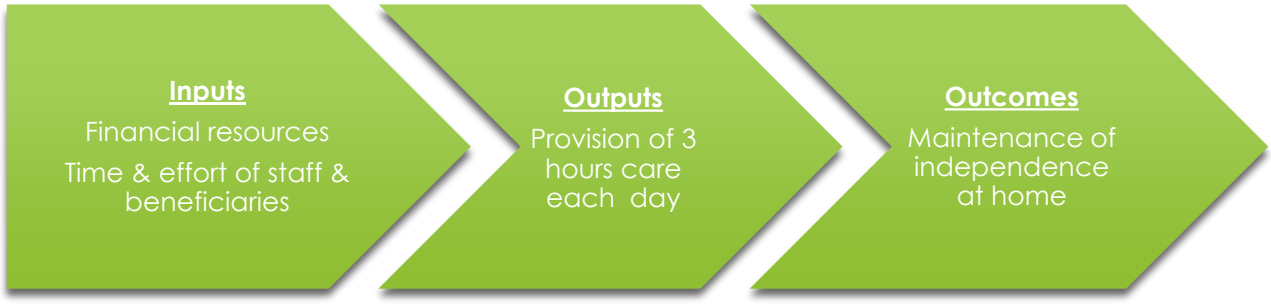
[8] Social Value UK. www.socialvalueuk.org
[9] https://socialvalueuk.org/principles-of-social-value/

change included within the SROI analysis (before the impact of outcomes is calculated).

*Figure 6 – Outline of the chain of change*


SROI is an outcomes-measurement approach, and only when outcomes are measured is it possible to understand if meaningful changes are happening for the stakeholders. To illustrate this idea, Figure 7displays a brief chain of change for a domiciliary care programme to assist people to remain in their own homes - only by measuring the final outcome is it possible to understand the impact of the care programme.

*Figure 7 – Example of a chain of change*




As will be discussed at the point of analysis, SROI also incorporates accepted accounting principles such as deadweight and attribution to measure the final impact of activities that are a result of each activity or intervention. Importantly, SROI can capture positive and negative changes, and where appropriate these can also be projected forward to reflect the longer-term nature of some impacts. Any projected impacts are appropriately discounted using the Treasury's discount rate (currently 3.5%). The formula used to calculate the final SROI is;

**SROI = Net present value of benefits**
**Value of inputs**

**So, a result of £4:1 indicates that for each £1 invested, £4 of social value is created**

Overall, SROI can create an understanding of the value of activities relative to the costs of creating them. It is not intended to reflect market values, rather it is a means to provide a voice to those material stakeholders and outcomes that have been traditionally marginalised or ignored.

Only by measuring outcomes are organisations able, not only to demonstrate their impact, but also importantly to improve them. This thereby strengthens accountability to those to which they are responsible, which, in the case of the third sector is fundamentally the key beneficiaries of services.

## 5.0 Stakeholder Engagement

Including stakeholders (Principle 1) is the fundamental requirement of SROI. Without the involvement of key stakeholders, there is no validity in the results – only through active engagement can we understand actual or forecasted changes in their lives. Only then can SROI value those that matter most.

To understand what is important for an analysis, the concept of materiality is employed. This concept is also used in conventional accounting and means that SROI focuses on the most important problems faced by the stakeholders, and their most important outcomes, based on the concepts of relevance and significance (see Figure 8). The former identifies if an outcome is important to the stakeholders, and the latter identifies the relative value of changes. Initially, for this evaluation of Arfon Community Link, a range of stakeholders were identified as either influencing or being affected by the project – Table 1 highlights each stakeholder, identifying if they were considered material or not for inclusion within the SROI analysis. Table 1 below also shows the number and type of stakeholder engagement made for the analysis.

*Figure 8 - Materiality principle*

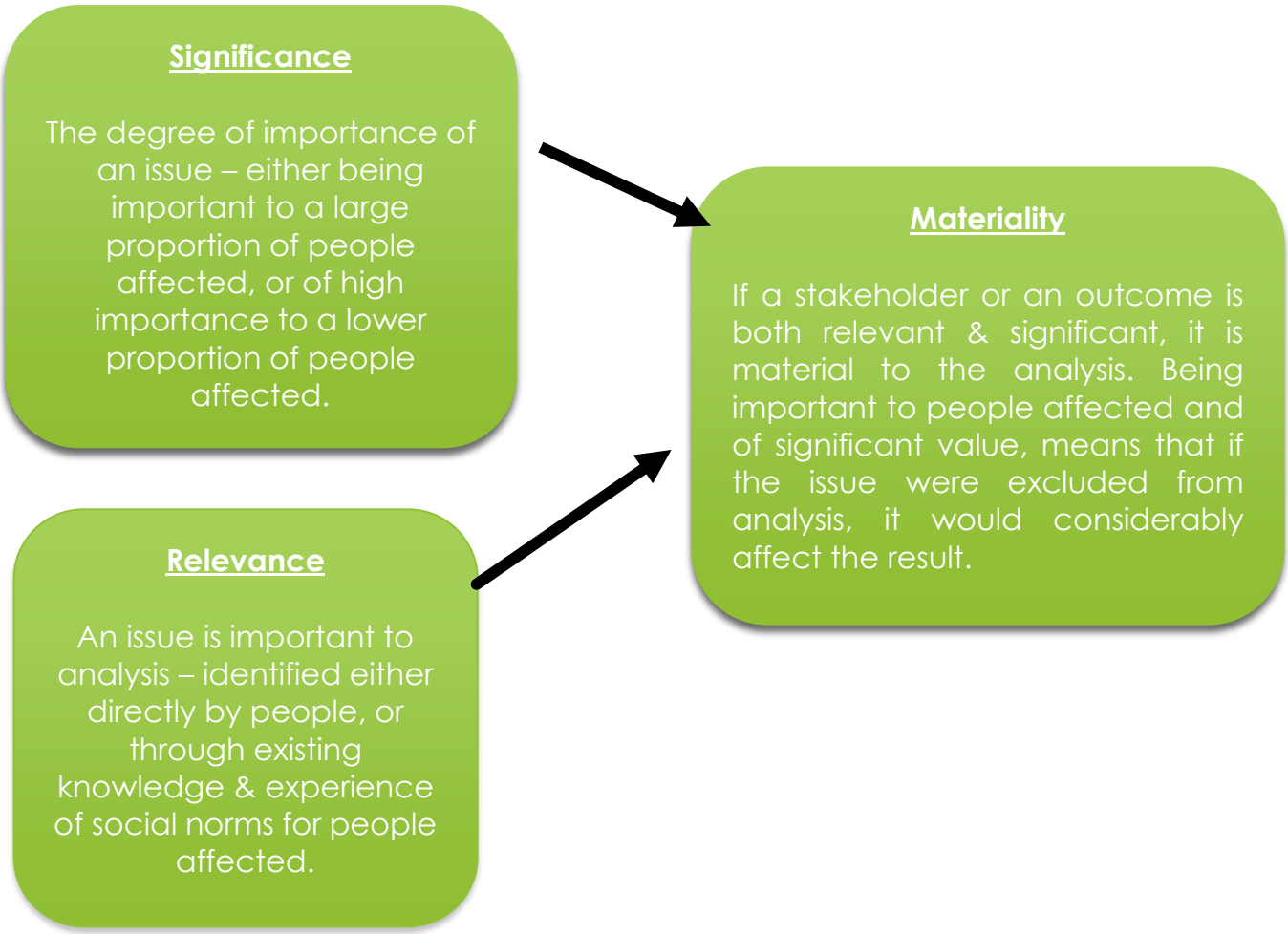


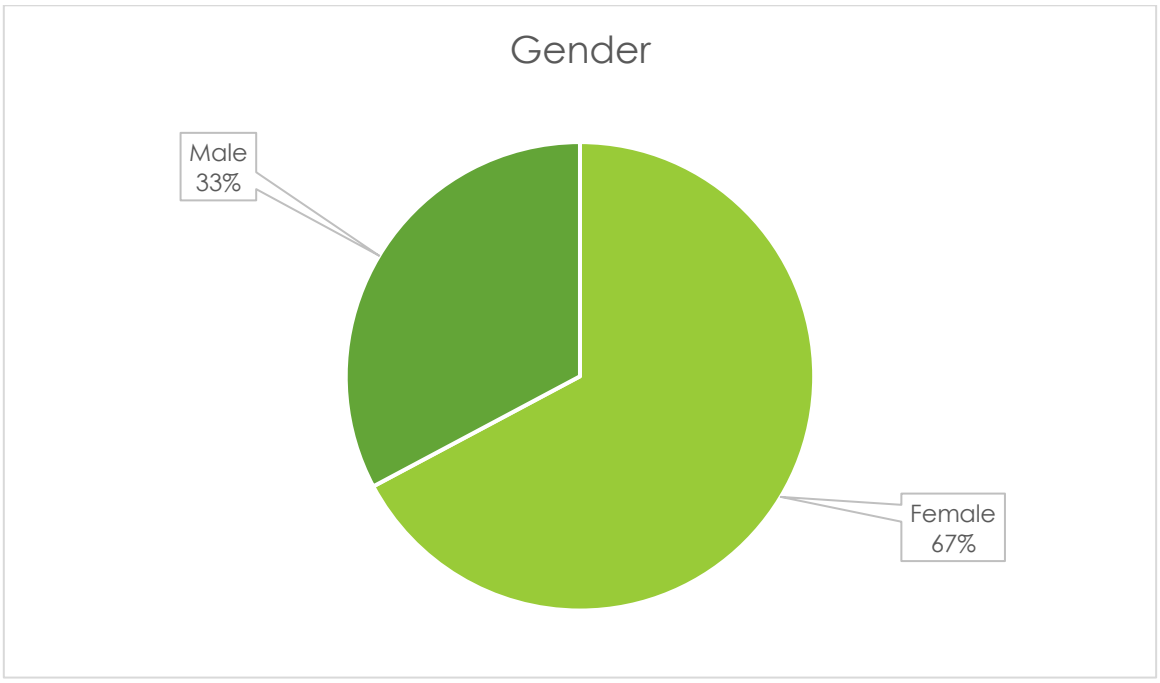
*Table 1 - Engagement with stakeholders and materiality*

| Stakeholder | Population size | Material stakeholder? | Method of engagement |
|---|---|---|---|
| **Clients** | 220 | Yes – they are the main beneficiaries of the project and experience the material outcomes identified in this report. | - 2 in-person interviews<br>- 5 phone interviews<br>- 6 survey responses<br>- 60 Pre and Post score responses to ONS 1,2,3 & 4 on the Elemental platform |
| **Referral partners and agents** | 40 | No – the referral partners work alongside the CLO to support the needs of the clients | - 5 online interviews with partners and referral agents |

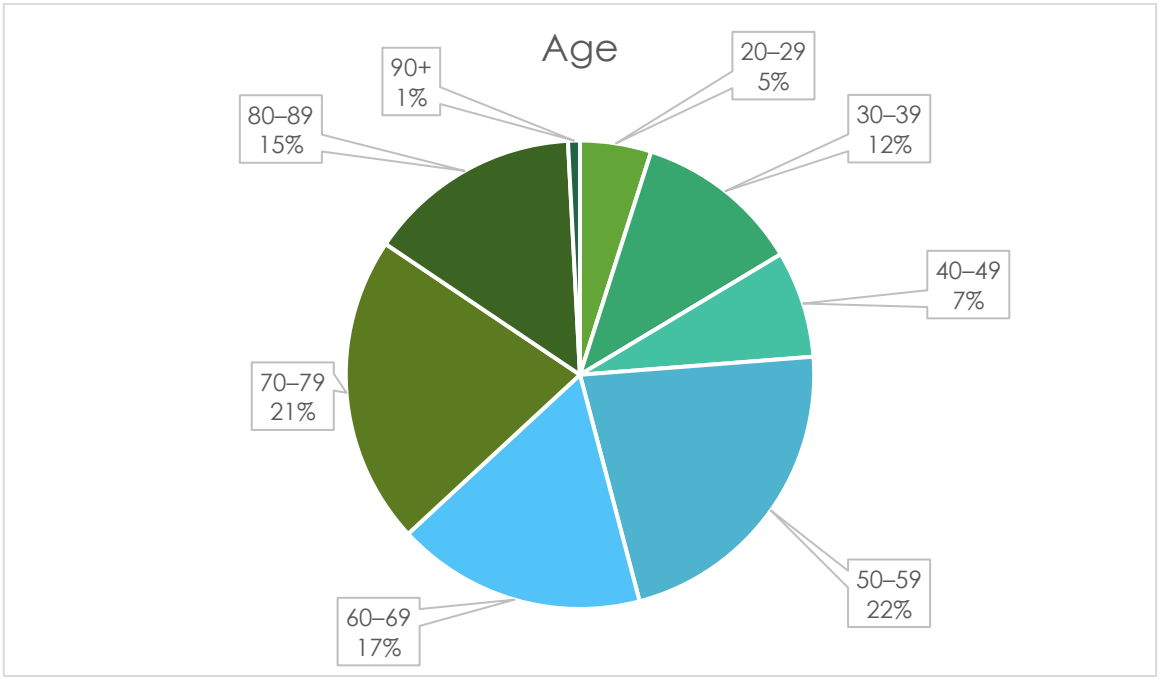
## The potential subgroup of stakeholders

Individuals, communities, and groups differ significantly, and analysing results by key characteristics helps identify diverse needs and supports better decision-making. This section reviews charts and project characteristics to highlight potential client subgroups such as gender and age based on information provided through the Elemental platform.

Gender


Gender
Male
33%
Female
67%

Age


Age
90+
1%
20–29
5%
80–89
15%
30–39
12%
40–49
7%
70–79
21%
50–59
22%
60–69
17%

## 6.0 Project Inputs

This service is free to those who receive it; however, some non-financial inputs are also necessary to ensure any changes. Clients' willingness to engage with the CLO 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 total financial input of **£63,950** is forecasted for the period of analysis, funded by Betsi Cadwaladr University Health Board (BCUHB). This includes **£61,917** in project funding and the additional **£2,034** of financial input is based on the need for healthcare professionals and other organisations to make referrals and spend time with the clients. It is appropriate to include an additional input that values this time contribution. Therefore, the approximate cost for each referral agent is calculated (please see table 2). For example, based on the opportunity cost of not providing services directly to other individuals, the cost of a typical GP appointment of £45 is employed for referrals from this source. The total costs for the project can be seen in Table 3.

*Table 2 - Referral costs to the project by the healthcare professionals*

| Referral agent | Task | Value | Source |
|---|---|---|---|
| **General Practitioner** | Initial referral – estimated 10 minutes each. | £45 per GP appointment – used to represent 1 appointment per referral made (29 referrals X £45). Therefore, a total cost of **£1,305** | PSSRU Health and Social Care Costs, 2024- page 74[10] |

[10] PSSRU 2024, P72

| | | | |
|---|---|---|---|
| **Self-referral** | Initial referral – estimated 10 minutes each | £12.21 per hour based on current living wage (101 referrals x (12.21/6)) therefore total cost of **£205.54** | Gov.co.uk [11] |
| **Community Mental Health Teams** | Initial referral – estimated 10 minutes each. | £52 per hour of individual-related work (22 referrals X (£52/6)). Therefore, a total of **£190** | PSSRU Health and Social Care Costs 2024, page 100 |
| **Occupational Therapists** | Initial referral – estimated 10 minutes each. | £44 per hour of local authority-operated occupational therapists (band 5) 26 referrals X (£44/6)). Therefore, a total cost of **£190** | PSSRU Health and Social Care Costs, 2024 page 96 |
| **Other NHS services** | Initial referral – estimated 10 minutes each | £43 per hour of individual-related work (Band 4)(11 referrals X (£43/6)). Therefore, a total cost of **£78.83** | PSSRU Health and Social Care Costs 2024, page 100 |

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

| | | | |
|---|---|---|---|
| **3rd sector organisations** | Initial referral – estimated 10 minutes each | £12.21 per hour based on current living wage (16 referrals x (12.21/6)) therefore total cost of **£22** | Gov.co.uk [12] |

**Table 3 - Total Monetised Inputs for Arfon Community Link project**

| Stakeholder | Financial input | Non-financial input | Cost per individual |
|---|---|---|---|
| **Individuals** | N/A | Willingness to take part and take action identified by the Community Link Officer | |
| **Mantell Gwynedd – manage funding by BCUHB** | **£61,917** | Strategic management, time, expertise | |
| **NHS** | **£2,034** in additional referral cost | £2,034 of value for the time taken for healthcare professionals to refer people to the Community Link | |
| **3rd sector services** | **£22** | Cost to refer 16 individuals to the project through various services | |

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

| | | |
|---|---|---|
| **Totals** | **£63,950** | **£290 per individual** |

# 7.0 Outputs, Outcomes and Evidence

## 7.1 Outputs

The outputs for the Arfon Community Link project are the number of referrals made to the project and how many hours of support each person received from the Community Link Officer. Over the period April 2025 – January 2026, there were **183 referrals** based on data reported on the Elemental platform**.** This report will also include the forecasted number of referrals for February & March with an additional **37 referrals** included, as shown in Table 4. Therefore, for example, there were 12 self-referrals between April 1st 2025 and January 31st and an additional 2 months have been forecasted for February and March 2026. The same calculation has then been made for all referral routes, gives a total number of referrals for the project in the period of analysis of **220**.

However, to avoid overclaiming the social value created by the project from April 1st, 2025 - March 31st, 2026, **119 (60%)** of individuals who supported the project will be included in the value map. This is in line with the previous 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 4 below shows a breakdown of how the 220 individuals are referred to the project.

*Table 4 - Source of Referral*

| Source of Referral | Number of Individuals referred between April 1st 2025 to January 31st 2026 | Forecasted referral for 2026 (February 1st – March 31st) | Total number of referrals | Percentage of referrals |
|---|---|---|---|---|
| **GP** | 24 | 5 | 29 | 13% |
| **Community Mental Health Team** | 18 | 4 | 22 | 10% |

| | | | | |
|---|---|---|---|---|
| **Occupational Therapists** | 22 | 4 | 26 | 12% |
| **Self-referral** | 84 | 17 | 101 | 45% |
| **Re-referrals** | 17 | 3 | 20 | 9% |
| **Other NHS services** | 9 | 2 | 11 | 5% |
| **3rd sector organisations** | 9 | 2 | 11 | 5% |
| **Total** | 183 | 37 | 220 | |

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 inquiries. However, it should be noted that during 2025/26 the Link Officer has been dealing with some very complex cases that sometimes can take months to complete.

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 upon, where individuals start getting involved in various activities and/ or organisations depending on their personal needs.

The CLO continues to work closely with the GPs from various surgeries across Arfon. There are 29 total referrals from GPs (13% of total referrals) through a direct referral, and 101 people given self-referral card were made to the CLO during the period of analysis, the highest referral path by a distance. This shows how important the Community Link project is to the GPs of Arfon, and how the GPs can trust the work of the CLO will help their patients deal with various complex matters.

## 7.3 Outcomes

All the data for the outcomes is collected and analysed through the Elemental platform and has been since 2021. The Elemental software helps organisations to enhance the impact of their social prescribing programs via their digital social prescribing products and data collection services/database[13].

Using the 'health 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, 2, 3 & and 4 for data collection surveys. The questions are set to measure people's well-being for life satisfaction, worthiness, happiness, and anxiety, and are a part of the Measuring National Well-being developed in 2011.

The ONS are measured using pre and post score, measured on a 1-10 scale. For this analysis, only clients who have reported a pre and post score have been included, ensuring we are not overclaiming the impact created by the project.

The ONS metrics do not include improved physical health, for this outcome an internal measuring metric was used. A rating scale of 1-10 was used to ensure the level of change experienced by the clients and to match the same reporting metrics reported on the Elemental platform. The three outcomes identified for the Arfon Community Link Project align with the long-term outcomes goals of the NFfSP and the new Welsh Government Mental Health Strategy.

Furthermore, for this evaluation we also sent out a second survey to capture more social value orientated data (such as value, and counterfactual questions) to compliment the data collected on Elemental. Thus, giving a more holistic view of the changes experienced by the clients of the project. A theory of change was then constructed (please see appendix 2) to show the path and outcomes clients experience while being supported by the CLO.

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:

[13] https://www.gov.uk/g-cloud/services/209867697068843

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

These were the outcomes that need to be continuously managed and have been over the course of the decade of the project to date. Through analysis of the ongoing 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 evolved, we needed to reassess and confirm the outcomes identified were relevant and still held up to the materiality test. With continuous engagement throughout the year with staff members and interviews with some clients, there is the confidence that the outcomes are still relevant and hold significant value for the clients.

Outcome 1 – Clients are signposted to a suitable organisations and groups based on their non-clinical needs. As a result, clients have increased opportunities to meet new people and socialise, therefore, feel less alone in their situation and experience a **reduced feeling of social isolation and loneliness.**


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 for statutory services.

Loneliness and isolation can have an impact on many individuals of any age, gender, or other socio-economic factors. Individuals were asked about their level of social interaction, about feeling part of the community, and the impact on their mental well-being.

This can be seen in the Arfon Community Link project with **29 direct referrals from GPs and 101 self-referrals (a card given by GPs surgeries)** made to the Arfon project in the past year(58% of total referrals made to the project).

The high number of referrals made by GP surgeries over the past year highlights that many people in the community continue to experience significant levels of isolation and loneliness, and the need for the project to keep supporting individuals. Also, given the longevity of the project and past success of supporting clients, GPs have trust that the work and guidance the CLO is able to give to clients can support their non-clinical needs.

This is where the work of the CLO plays an important part, the CLO is able to speak and give time to clients, make them feel heard and listened to. Although a small part of the chain to tackle loneliness, this in some cases is the important part for clients.

The CLO then creates an action plan that is bespoke to each client, whether that is helping the clients find groups within the third sector to participate in or it may be more one-to-one time with the CLO, understanding the root cause of why the client is feeling lonely to begin with. However, in reality the support does not stop either, the CLO often is only ever a phone call away for clients ensuring they do not feel alone even after they have been supported.

Furthermore, the referral agents we engaged with also mentioned that because the CLO is able to spend more time with the clients, they are able to work together closely to identify the underlying factor of the clients issues, of which loneliness or social isolation is a common theme. The referral agents is then better place and informed to support their clients, which in turn takes pressure off the medical professionals and they are able to use their resources more effectively and efficiently – and therefore they are able to see more clients as a result.

Based on the data collected, **94%** of individuals reported feeling less lonely and isolated, and said they were re-engaging with their community activities and groups. And being in contact with the Community Link Officer—either through regular phone support or simply knowing the officer was available when needed.

The average level of change experienced was **81%**, indicating a substantial positive impact on clients' feelings of isolation and loneliness. This evidence continues to demonstrate that the CLO plays an important role in tackling loneliness and isolation, helping to ease pressure on both primary and secondary NHS services within the community.

Outcome 2 - Clients feel listened to and supported without judgement by the Community Link Officer, and through effective due diligence the officer is well placed to signpost clients to the most appropriate organisation, helping them resolve their issues and ultimately **improving their mental health.**


The CLO has strong working relationships and a wide knowledge base of relevant organisations, which enables the officer to support clients who are worried about problems affecting their mental health. The officer undertakes the necessary due diligence to fully understand each client's situation and is then able to signpost them to the most appropriate organisation.

Over recent years, many of the clients supported by the CLO have been referred to the project because they are experiencing financial hardship due to the ongoing cost-of-living crisis, which has had a negative impact on their mental health. The CLO has supported many clients who were worried about rising bills; in some cases, clients were on incorrect tariffs or had been billed inaccurately, leaving them paying more than necessary and placing them under financial strain.

Many clients are unsure how to challenge incorrect or rising bills, and this uncertainty can negatively affect their mental well-being. The support provided by the CLO is therefore essential. The CLO researches alternative tariffs that clients may qualify for and communicates directly with billing organisations on their behalf to secure the best possible financial outcome. By taking on this responsibility and advocating for clients, the CLO helps to relieve clients stress and worry, which in turn contributes to improved mental well-being.

*"Rhian has helped me with reducing my water bill, I could not have done it without her." – Client*

By carrying out thorough due diligence and preparing each client's case before signposting them, the CLO ensures that organisations such as ADRA, Citizen's Advice and Cyngor Gwynedd are better informed and able to provide effective support. This approach increases organisational capacity and improves their ability to support more clients.

*"Rhian goes beyond what the service is meant to deliver." – Referral agent*

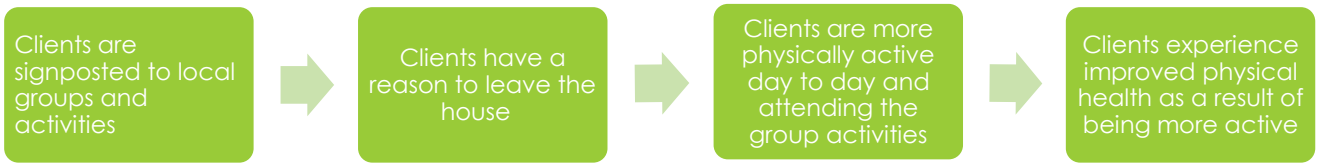
The CLO's support extends far beyond helping clients with their bills. By the time many individuals are referred to the project, they have often already attempted to seek help for issues affecting their mental health but have been unsuccessful for various reasons. Clients consistently reported that the CLO listens without judgement and takes the time to understand their situation. This non-judgemental approach helps clients feel comfortable opening up about their challenges, enabling the CLO to better understand their needs and provide more effective support.

Having someone to talk to at a point of crisis has a positive impact and reduces the likelihood of clients' situations worsening. It cannot be emphasised enough

how significant the project's contribution has been in improving clients' mental well-being.

From the survey data collected, **72%** of clients reported improved mental well-being due to the support provided by the project, with an average level of change of **81%.**

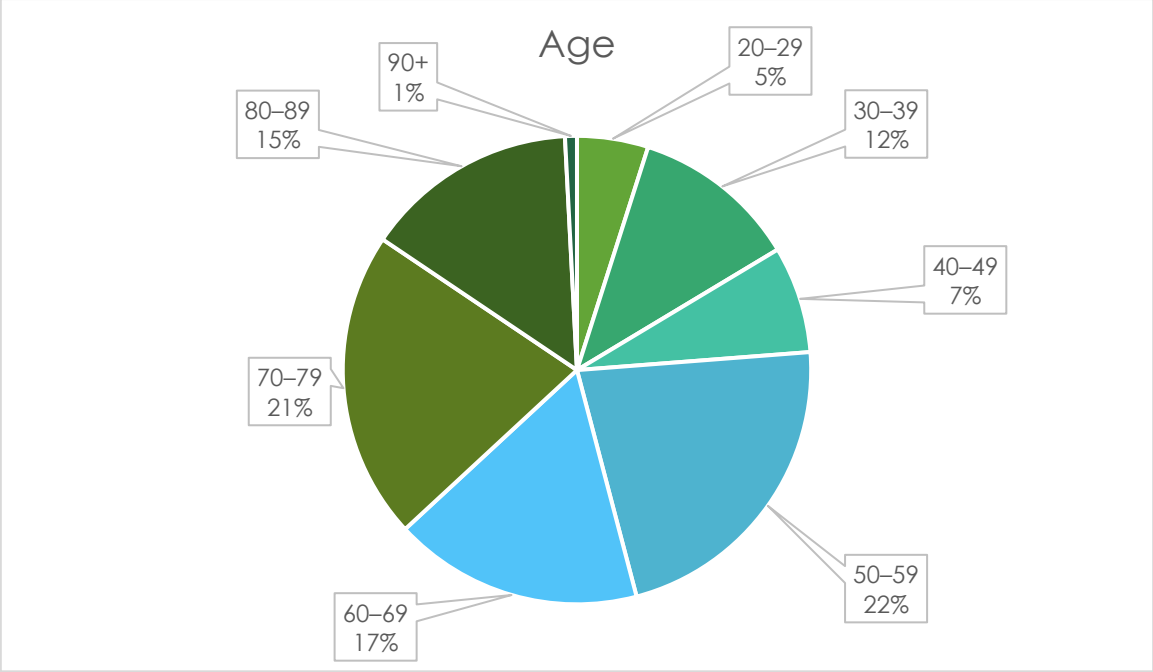
## Outcome 3 – Clients experience **improved physical health** due to being signposted to local groups and activities and becoming more physically active as a result




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 reduce their visits to the GP or other NHS services.

The chart below shows that 54% of the clients referred to the project in 2025/26 are over the age of 60, therefore, this can limit the amount of change a person can experience in their physical health.




As part of the process, as discussed, the CLO will develop an action plan based on the needs of the clients. Being able to develop a better understanding of a person hobbies can help the CLO refer the clients to the group / organisation, and this is only possible because the CLO is able to spend valuable time with each client.

By attending the groups and activities the clients are referred to, they are able to get out of the house on a more regular basis, and they generally become more physically active as a result. Also, there is strong evidence that being more physically active leads to improved overall wellbeing, according to the Social Prescribing Academy;

*"There is a wealth of evidence to show the benefits of physical activity for health and wellbeing. And when people take an active role in shaping their care and support, their health outcomes are even better. Social prescribing enables people to take an active part in their own journey. Ensuring the help, they receive is as unique as their individual challenges and needs".* [14]

14 https://socialprescribingacademy.org.uk/what-is-social-prescribing/physical-activity-and-social-prescribing/

The total number of clients experiencing positive change in their physical health is **84%**, up from **46%** last year. The amount of change clients experience on average is **75%**. The equivalent to the clients experiencing quite a lot of change or a lot of change in their physical health.

In the case of Arfon Community Link clients, all three outcomes interrelate and reinforce one another to enhance overall well-being. Clients are referred to community-based activities that align with their needs, particularly to support social engagement for those experiencing loneliness or isolation. Regular participation in these activities contributes to improved physical health, and, in turn, the combination of increased physical activity and sustained social interaction supports improved mental well-being. Collectively, these positive changes reduce the likelihood of clients seeking GP or other statutory health services appointments for non-clinical needs, thereby alleviating pressure on already stretched services.

### Referral partners and agents' feedback

During the interviews with referral partners and agents we discussed how they believe the Arfon Community Link project is supporting their clients. In interviews, referral partners were shown the clients' Theory of Change (Appendix 2) and asked to share their views and help verify the findings. All five partners agreed that the identified outcomes remain relevant for clients, particularly improvements in mental health.

Partners highlighted that the CLO is able to spend sufficient time with clients to develop a thorough understanding of their needs. By the time many individuals are referred to the project, they are often at a point of crisis and value having someone who can take the time to listen, offer reassurance, and help put their minds at ease where possible. Therefore, there is strong confidence that the outcomes being measured in this report continue to be material and have been since the project launched in 2016

In addition, interviews examined the effect of the Arfon Community Link project and the CLO's support on referral partners and agents. Partners described many positive aspects of working with the CLO; however, two outcomes were particularly evident, trust in the professional service provided and increased capacity within their own roles.

### Trust and increased capacity.

The referral partners and the CLO work collaboratively to ensure that clients receive the most effective and holistic support possible. Over time, strong professional relationships have been established, alongside a clear and shared understanding of the respective roles each party plays in supporting clients. Given the Arfon Community Link project's demonstrated success in supporting over 2,000 individuals to date, referral partners have developed a high level of confidence and trust in the CLO's ability to provide appropriate, consistent, and comprehensive support. This trust enables referral partners to confidently refer clients to the Arfon Community Link project for additional, non-clinical support, knowing that their needs will be addressed effectively. As a result, referral partners are better able to manage their own workloads, increase their capacity to see and support more clients, and focus on their core responsibilities. This collaborative approach strengthens the overall support system for individuals and contributes to more efficient use of services across the community.

*I have a good relationship with the team at Mantell and have had over a number of years. I have a lot of trust in Rhain that she will be able to support the clients in a holistic way, helping resolve the root cause of their problems. I have additional capacity because of Rhian's work, and she goes above and beyond what is required of her to support the clients. Also, a mention for the admin of the project, she is always friendly, approachable and professional. Her role is vitally important to the project, and I can always rely on her to organise and support the project. – NHS referral agent*

## No change or negative outcomes?

As stated in the previous report, some clients had experienced no change. Looking at the sample of data, **6%** of clients experienced no change, this represents 11 individuals. Consideration should be given 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.

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 experienced significant change, and some social value and positive change has been created to improve clients' mental well-being.

# 8.0 How do the outcomes relate to the Well-being of Future Generations (Wales) Act?

## What is The Well-being of Future of Generations (Wales) Act?

*"The Well-being of Future Generations (Wales) Act is about improving the social, economic, environmental, and cultural well-being of Wales. The Act gives a legally binding common purpose – the 7 Well-Being Goals – for national government, local government, local health boards, and other specified public bodies. It details how specified public bodies must work and work together to improve the well-being of Wales. It will make the public bodies listed in the Act think more about the long-term, work better with people and communities and each other, look to prevent problems and take a more joined-up approach. This will help to create a Wales that we all want to live in, now and in the future."* [15]

All three outcomes identified for the client centre around well-being goals of the Future Generation (Wales)Act. Because of the emotional and practical support and guidance offered by the CLO and ensuring the clients are signposted to the relevant organisations to suit their needs.

As discussed, the clients experience many benefits and outcomes due to support and guidance provided by the CLO. As identified the clients experience both mental and physical well-being outcomes, these outcomes link to the 'A Healthier Wales' goal of the Future Well-being of Generations Act. 'A Healthier Wales' is defined as "*A society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood.*" Therefore, the outcomes identified in this report follow this goal's definition and the Arfon Community Link project is helping to support improving the well-being of its clients.

[15] futuregenerations.wales

## 9.0 Value

The difference between 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 the 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. Table 5 below shows the average weighting given to the outcomes, demonstrating that positive changes in their mental health the most valuable to the individuals. The outcomes were weighted out of 10.

*Table 5 - Value*

| Outcome | Value (out of 10) |
|---|---|
| **Improved mental health** | 9.0 |
| **Reduced loneliness and isolation** | 8.0 |
| **Improved physical health** | 8.0 |

# Case Study: Transport Difficulties for an Older Patient Referred for Cataract Surgery

## Background

This case study outlines the experience of a 72-year-old person living alone somewhere in Pen Llŷn The patient does not drive, has no close family support, and depends on public transport. After being referred for cataract surgery, the patient faced several barriers due to cancelled appointments, long travel distances, and unclear guidance on transport support.

## Referral and Appointment Changes

The patient was first scheduled to have surgery at his local hospital, but several last-minute cancellations meant the referral was moved to an NHS-contracted clinic in Shrewsbury, England. Two appointments were arranged:

- A pre-operative assessment
- Cataract surgery one week later

## Challenges With Transport

Travelling to Shrewsbury from the patient's home required a long, complicated journey involving lifts, trains, and buses. No transport help or financial support was offered. This meant the patient had to plan the entire journey alone. To attend the pre-operative appointment, the patient would have needed to:

- Arrange an early-morning lift to the nearest train station, as no buses were running
- Take a train, possibly with changes
- Use a bus from Shrewsbury station to the clinic
- Complete the same journey on the way home

The patient felt they had no option but to complete this difficult trip independently. They were also worried about the return journey after surgery, as cataract procedures can temporarily affect vision. They believed they might have to pay for overnight accommodation in Shrewsbury to avoid travelling home immediately after the operation.

**Advocacy and Attempts to Arrange Support**
A neighbour familiar with NHS processes became aware of the situation and raised concerns about the patient's safety.
Several organisations were contacted for help:

- Hospital transport services
- National charities
- Community transport groups
- Mantell Gwynedd

Hospital transport initially refused assistance, stating they did not take patients to appointments in England. Other organisations said they could not help or could only offer support at a high cost—around £200 per journey.

The case was then referred to the **Older People's Commissioner for Wales** through the advice and guidance given by the **Arfon Community Link Officer**, who reviewed the situation. The Commissioner found that the initial refusal was incorrect and that the patient was, in fact, entitled to hospital transport support.

**Result of advocacy**
Transport was eventually arranged—but only for the day of the surgery. By then, the patient had already travelled to Shrewsbury alone for the pre-operative appointment. For the surgery, the health board booked a private taxi. The driver reported that:

- They were only told about the arrangement the night before
- They lived a long distance from the patient's village

This led to an inefficient journey:

- The driver travelled from Rhyl area to the patient's home in Pen Llŷn
- Drove the patient to Shrewsbury
- Waited during the surgery
- Returned the patient home to Pen Llŷn
- Then drove all the way back to Rhyl

This raised concerns about whether more suitable, local, or better-coordinated transport options could have been used.

**Learning Points**

This case highlights several issues:

- Unclear cross-border transport processes: There was no clear policy for patients referred to clinics in England.
- Incorrect information from hospital transport services: The initial refusal caused unnecessary stress and delay.
- Safety concerns: Expecting an older patient to navigate long and complex public-transport journeys for essential surgery was unsafe.
- Inefficient use of resources: The final taxi arrangement was arranged late and appeared costly and poorly planned.

**Implications for Future Practice**

To prevent similar problems, the following improvements should be considered:

- Clear and consistent policies for patients attending clinics in England
- Better communication between transport teams and other departments
- Earlier planning and use of local transport providers
- Stronger emphasis on patient wellbeing, especially for older or isolated individuals

## 10.0 Establishing Impact

When assessing the social value created through a project or service, one of the considerations is how much of the change is actually caused by our activities. The main considerations are:

- Deadweight
- Attribution
- Displacement
- Duration and drop off

The questions were asked during this initial qualitative and quantitative data collection and consideration is given to any changes annually based on services available or a change in service.

### 10.1 Deadweight

Deadweight allows us to consider what would happen if the service were not available. There is always a possibility that the clients would have received the same outcomes through another activity or by accessing support elsewhere. Please see table 6 below for deadweight level given and the justification.

*Table 6 - Deadweight*

| Outcome | Deadweight | Justification |
|---|---|---|
| **Improved mental health** | 30% | For all three outcomes, a counterfactual level of 30% was included. Many of the clients have mentioned that the changes they experienced may have not happened without the support given by the Community Link Officer. |
| **Reduced loneliness and isolation** | | |
| **Improved physical health** | | |

## 10.2 Attribution

Attribution allows us to recognise the contribution of others towards achieving outcomes. There is always a possibility that others will contribute towards any changes in people's lives, such as family members or other organisations. Please see table 7 below for attribution level given and the justification.

*Table 7 - Attribution*

| Outcome | Attribution | Justification |
|---|---|---|
| **Improved mental health** | 60% | Many of the clients are supported by the link officer to deal with their case and the issues they face. However, many of the clients are signposted and referred to other organisations such as Rhyl City Strategy, ADRA, Citizen's Advice and The Older People Commissioner for specialist advice and guidance to best resolve their case. Therefore, a medium level of attribution is deemed appropriate for all outcomes and reducing the risk of potentially overclaiming and in-line with pervious evaluations. |
| **Reduced loneliness and isolation** | | |
| **Improved physical health** | | |

## 10.3 Displacement

We need to consider if the outcomes identified in this analysis displaced other outcomes elsewhere. For example, if we deal with criminal activity in one street, have we just moved the problem elsewhere?

For this analysis, there were no displacement factors deemed appropriate based on primary stakeholder engagement and secondary research, therefore 0% displacement was included in the value map for all outcomes.

## 10.4 Duration and Drop Off

Each outcome has a duration of one year, and as this evaluation covers only that period, it was not necessary to apply any drop-off.

## 11.0 SROI results

This section of the report presents the overall results of the SROI analysis of the social prescribing model service provided by Mantell Gwynedd. Underpinning these results are the eight SROI principles that 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 CLO can guide them through what is available and assist them with taking the first steps to change. This has 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 8 below indicate a positive return for individuals who were referred to the CLO and experienced positive outcomes based on current data.

*Table 8 - Present Value Created per Individual Involved*

| **Stakeholder** | **Average value for each individual involved** |
|---|---|
| **Individuals** | £1,287.13 |

The overall results in Table 9 highlight the total value created, the total present value (discounted at 3.5%), the net present value, and ultimately the SROI ratio.

*Table 9 - SROI Headline Results*

| **Total value created** | **£** |
|---|---|
| **Total present value** | £283,169.41 |
| **Investment value** | £63,939.82 |
| **Net present value (present value minus investment)** | £219,229.59 |
| **Social Return on Investment** | **£4.43** |

**The result of 4.43:1 indicates that for each £1 of value invested in Community Link, Arfon Social Prescribing Model, an estimate of £4.43 of value is created.**

## 12.0 Sensitivity Analysis

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

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

If the outcomes were to have one element changed, this would show a difference in the SROI result as seen in Table 10. This adds confidence in the results and in all of the judgments made during this analysis. From the sensitivity analysis in Table 10 below, the social value evaluation can be estimated to be between **£3.32 and up to £5.54** for every £1 invested. The assumptions used in the value map estimate the social value is **£4.43**.

*Table 10 - Sensitivity Analysis*

| Factor changed | Revised SROI Ratio | Difference | Variance |
|---|---|---|---|
| Deadweight – reduce all outcomes deadweight level by 10% | £5.06 | +£0.63 | +14.22% |
| Deadweight – increase all outcomes deadweight level by 10% | £3.80 | -£0.63 | -14.22% |
| Attribution – reduce all outcomes attribution level by 10% | £5.54 | +£1.11 | +25.06% |
| Attribution – increase all outcomes attribution level by 10% | £3.32 | -£1.11 | -25.06% |
| Increase value of the financial proxy by 25% | £5.54 | +£1.11 | +25.06% |
| Reduce value of the financial proxy by 25% | £3.32 | -£1.11 | -25.06% |
| Increase the number of people included in the value map by 25 | £5.42 | +£0.99 | +22.35% |
| Reduce the number of people included in the value map by 25 | £3.55 | -£0.88 | -19.86% |

## 13.0 Limitations

This report has demonstrated that the Arfon Community Link project creates positive social value for its clients' well-being through the outcomes identified. However, one key limitation of this evaluation relates to measuring whether the project has led to a reduction in clients' use of other statutory services. For example, it remains unclear whether clients visit their GP less frequently after receiving support from the CLO.

During interviews, many clients reported that they no longer rely on GP appointments to address feelings of loneliness, as they have begun taking part in activities such as volunteering. Clients were also asked in the survey how often they now depend on other statutory services following support from the CLO.

However, the qualitative data collected through the survey was not sufficient to confidently determine whether there has been a measurable reduction in demand for these services, particularly as many clients reported difficulties in securing GP appointments. Although there is strong confidence that the Arfon Community Link project is helping to reduce pressure on statutory services, more consistent data collection is needed. Gathering this information on an ongoing basis would allow any potential cost savings to the state—such as reduced appointments—to be captured and reflected in this and future evaluations.

## 14.0 Verification

As part of the verification process for this report, we adhered to the principles of social value—particularly Principle 1, which emphasises involving stakeholders as fully as possible. Given that all three client outcomes have been monitored and evaluated annually using the Social Return on Investment framework, we conducted semi-structured interviews with clients to confirm that the outcomes identified remain relevant.

We also engaged with referral partners through semi-structured interviews. These discussions reaffirmed the validity of the outcomes, providing greater confidence that the right outcomes continue to be evaluated.

Once all interviews were completed, a follow-up survey was issued to clients to collect quantitative data. The insights gathered from these surveys, alongside the ongoing data recorded on the Elemental platform, clearly demonstrate that the outcomes remain as relevant and material in 2026 as they were when the project first launched in 2016.

# 15.0 Conclusion and Recommendations

**This report has demonstrated that the Arfon Community Link has created over £280,000 of value, and for each £1 invested, £4.43 of value was created:**

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

The continued need for the Arfon Community Link project is evident, and the social impact findings presented in this report strongly reinforce this. The high volume of referrals received from a range of NHS departments—particularly local GP practices—demonstrates that the CLO continues to alleviate pressure on the local health board. This also reflects the strong and growing trust placed in the CLO by healthcare professionals, enabling a more holistic and coordinated approach to supporting clients.

The project also has a well-established track record of monitoring and evaluating outcomes, with this being the seventh annual social impact report. Over time, the findings have consistently demonstrated the positive difference the project makes to individuals who need support, especially those who are struggling with the ongoing cost-of-living crisis and the impact it has had on their mental health. The CLO has been able to guide, advise, and support clients effectively, helping them navigate complex challenges and identify suitable solutions. For those at crisis points—often facing increased financial pressures—the CLO is well positioned to continue offering timely, impartial, and practical support. This report also highlights the project's ongoing success in reducing loneliness and social isolation among clients through personalised and sustained engagement.

The Arfon Community Link project is a highly effective, preventative, and cost-efficient project with clear, measurable outcomes. It significantly improves client well-being, reduces loneliness, strengthens mental health, and alleviates pressure on statutory services. With rising demand and evidence of growing need across the county, continued and enhanced investment will maximise social value and support a more sustainable health and care system for Gwynedd.

The report has also demonstrated how the Arfon Community Link project aligns closely with three key legislations and frameworks in Wales, including the National Framework for Social Prescribing, The Well-Being of Future Generations (Wales) Act 2015 and the new Welsh Government Mental Health Strategy, with the importance placed on preventative care.

To increase the social value created by the project, some recommendations are proposed:

**1) Impact management and data collection**

As data has been collected consistently since 2016, Mantell Gwynedd has now adopted a social impact toolkit to support more detailed analysis of client groups. Some segmentation has begun by gender and age. These segments need to be continuously monitored moving forward. This will help deepen understanding of the different needs and experiences of service users, enabling the project to be managed in a way that maximises impact. Data should continue to be collected regularly to ensure future reports remain robust. Additionally, consideration should be given to reintroducing the measurement of more objective indicators—such as GP appointment frequency—as statutory services have now largely returned to normal operation since the pandemic. Some efforts were made to collect this data for this evaluation; however, more information is needed to be confident in the data to be able to include in the value map.

**2) Ensuring sustainable delivery across the county**

Demand for the project remains high, as demonstrated throughout this report. To sustain and extend its impact, more secure funding and additional support across the county are required. The increasing number of queries from individuals in Dwyfor and Meirionnydd further highlights the wider demand for the service. Expanding the project to these areas would enable the creation of even greater social value by reaching individuals living in communities with limited support options.

**3) Increasing project capacity**

At the time of writing, 40 individuals remain on the waiting list, further demonstrating the strong and growing demand for the service. Increasing project capacity would allow more people to receive support earlier, reduce pressure on statutory services, and enhance the overall social impact created.

# 16.0 Appendices

Appendix 1 – Value Map (separate excel document)

Appendix 2 – Clients Theory of Change

## Appendix 2 – Clients Theory of Change