COMMUNITY LINK SOCIAL IMPACT REPORT 2018-2019

"I felt so alone, I had no control over my life. There isn't a cure for my physical illness, but you have helped me cope and have put things in place to improve my quality of life. I don't feel constantly alone and scared anymore."

SOCIAL VALUE CYMRU

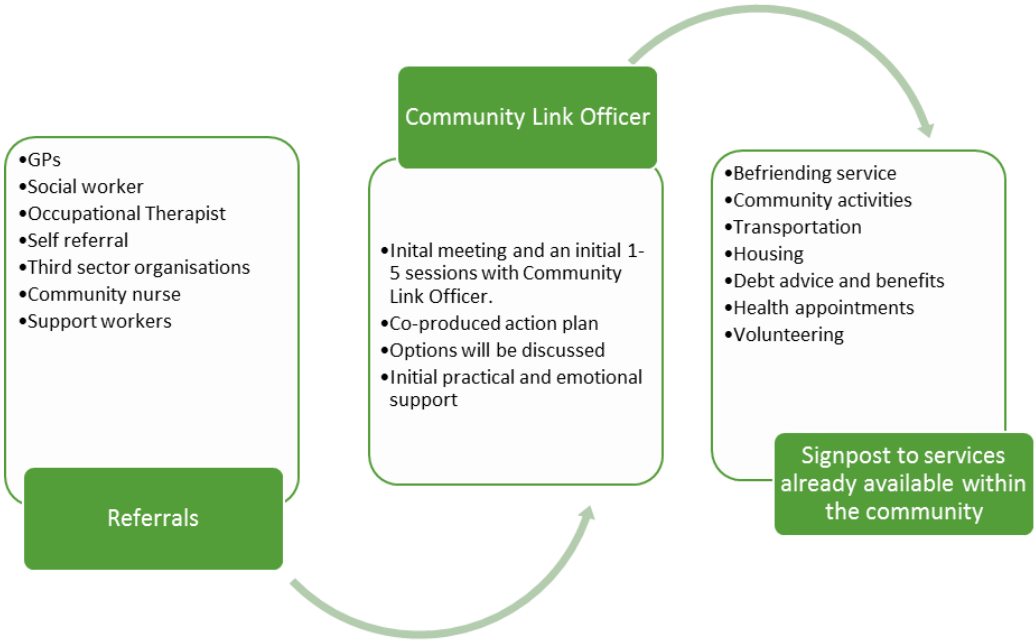
Introduction

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

A full report on the initial two years was published in September 2018. This report will analyse the social impact of the Community Link project in Arfon, provided by Mantell Gwynedd between the 1st October 2018 and the 30th September 2019. The impact of this service on individuals will be considered, but also the value to other statutory services, especially the Health Board.

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

Process of Referral



Project Inputs

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

The financial input is managed by Mantell Gwynedd. A financial input of £57,000 was provided for the 12 months period of analysis, funded through the Primary Care fund from Betsi Cadwaladr University Health Board.

In addition to necessary funding, a good working relationship between GPs and other clinical staff and the Community Link Officer, along with their willingness to refer individuals is essential towards the success of this project.

However, given the need for health care professionals to make referrals and spend time with the Officer, it is appropriate to include an additional input that values this time contribution. Therefore, the approximate cost for each referral agent is calculated (table 1) for example, based on the opportunity cost of not providing services directly to other individuals, the cost of a typical GP appointment of £37.40[1] is employed for referrals from this source. Total costs for the project can be seen in table 2.

Table 1 – Referral costs

Referral agent	Task	Value	Source
General Practitioner	Initial referral – estimated 10 minutes each.	£38 per GP appointment – used to represent 1 appointment missed per referral made (64 referrals X £37.40). Therefore, total of £2,393	

[1] Curtis, L. Burns, A. (2018) Unit Costs of Health and Social Care 2018. PSSRU.

			PSSRU Health and Social Care Costs 2018 page 127
Adult, health and well-being Services, Social Services	Initial referral – estimated 10 minutes each.	£43 per hour of individual-related work (35 referrals X (£43/6)). Therefore, total of £256	PSSRU Health and Social Care Costs page 174
Occupational Therapists	Initial referral – estimated 10 minutes each.	£43 per hour of local authority operated occupational therapists 11 referrals X (£43/6)). Therefore, total of £78	PSSRU Health and Social Care Costs page 177
Support Workers	Initial referral – estimated 10 minutes each.	£23 per hour for family support worker used (10 referrals X (£23/6)). Therefore, total of £30	PSSRU Health and Social Care Costs page 180

Table 2 – Total Monetised Inputs for Social Prescribing

Stakeholder	Financial input	Non-financial input	Cost per individual
Individuals / Patients	N/A	Willingness to take part and take action identified with the	N/A

		Community Link Officer	
Mantell Gwynedd – manage funding by Primary Care fund, BCUHB	£57,000	Strategic management, time, expertise	
NHS	£2,757 in addition to the funding above	£2,757 of value for the time taken to refer people to Community Link	
Totals	**£57,757**		**£240 per individual**

Outputs 2018-2019

The immediate outputs for the Social Prescription Community Link project, is the number of referrals made to the project and how many hours of support each person received from the Community Link Officer. Over the 12-month period October 2018 – September 2019 there were 272 referrals. By the 16th of September, 260 referrals had been made, but referrals were forecasted until the end of September. In total since the launch of the project, **654 of individuals have been supported through the programme since June 2016**. However, 9% of referrals are re-referrals and therefore we will consider the value for 248 individuals over the 12 months. Table 3 below shows a breakdown of how individuals were referred to the project. A small percentage do not meet the Community Link Officer on a face-to-face basis, as the information given to them via phone seemed to be sufficient. This is relevant to about 5% of individuals; however, they are still logged has having received a service and a review will still happen to see if there are any positive outcomes.

Table 3 – Source of Referral

Source of Referral	Number of Individual Referred	Percentage of Referrals
GP	64	25%
Mental Health Team	35	14%
Nurse	3	1.5%
Occupational Therapists	11	4%
Self-referral (card by GP)	116	46%
Support Workers	10	4%
Physio	3	1.5%
ED	1	0.5%
Probation	1	0.5%
Other services	7	3%

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

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

Outcomes

It is only by measuring outcomes that we can be sure that activities are effective for those that 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 eb continuously managed. Through analysis of the on-going quantitative indicators, consideration will be given as to how much change has occurred, but also whether the theory of change is still relevant. Any potential negative outcomes will be considered.

a) Reduced Loneliness and isolation

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

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

Having engaged with the individuals themselves, but also confirmed this with those who refer in to the project, as well as organisations who receive referrals from the Community Link Officer, it was clear that much of the problems all relate to feeling isolated with their communities or within the situations they find themselves.

“We felt alone and frightened nobody was listening to how serious my mum’s mental health issues and the affect it had on her and the whole family, the CL Officer went above and beyond to help and support me and my mum. The situation had become desperate and dangerous. But now things are back on track medication sorted bills finances, mum going out of the house not being frightened. I’m very grateful for the help and support.”

Based on the recent questionnaire results, 55% of individuals felt there was a positive change in feeling less lonely and isolated.

b) Improved mental health

Many of the referral organisations explained how much of the concerns are related to improving people with their confidence levels and for whatever reasons they are struggling with their confidence, this causes anxiety and stress for the individuals. Some for example might have caring responsibilities and therefore they have become isolated within their communities but have also developed problems with their own mental well-being.

“Gwerthfawrogi yr help ac yr anogaeth i fynd allan a trio pethau gwahanol. Y prosiect yn bwysig iawn i helpu bobl weld yr ochr orau ac be sydd allan yna i rhywun i wellai ffordd o fyw.”

However, to avoid over-claiming we based this on the same percentage of change as previously with 55% experiencing a positive change here with an average change of 28% in the quantitative assessment.

c) Improved physical health

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

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

Although some had experienced much change here, it wasn't relevant to as much individuals due to the reason that for many, they are living with conditions which will continue to have an impact on their physical well-being.

No change or negative outcomes?

As with the previous report, many clients had experienced no change. Looking at the sample of data, 42% of clients experienced no change, which represents 104 individuals. Consideration should be given as to why these individuals don't experience any change, and if inappropriate referrals are being made to the project. In the previous report, these clients were identified as follows:

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

Value

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

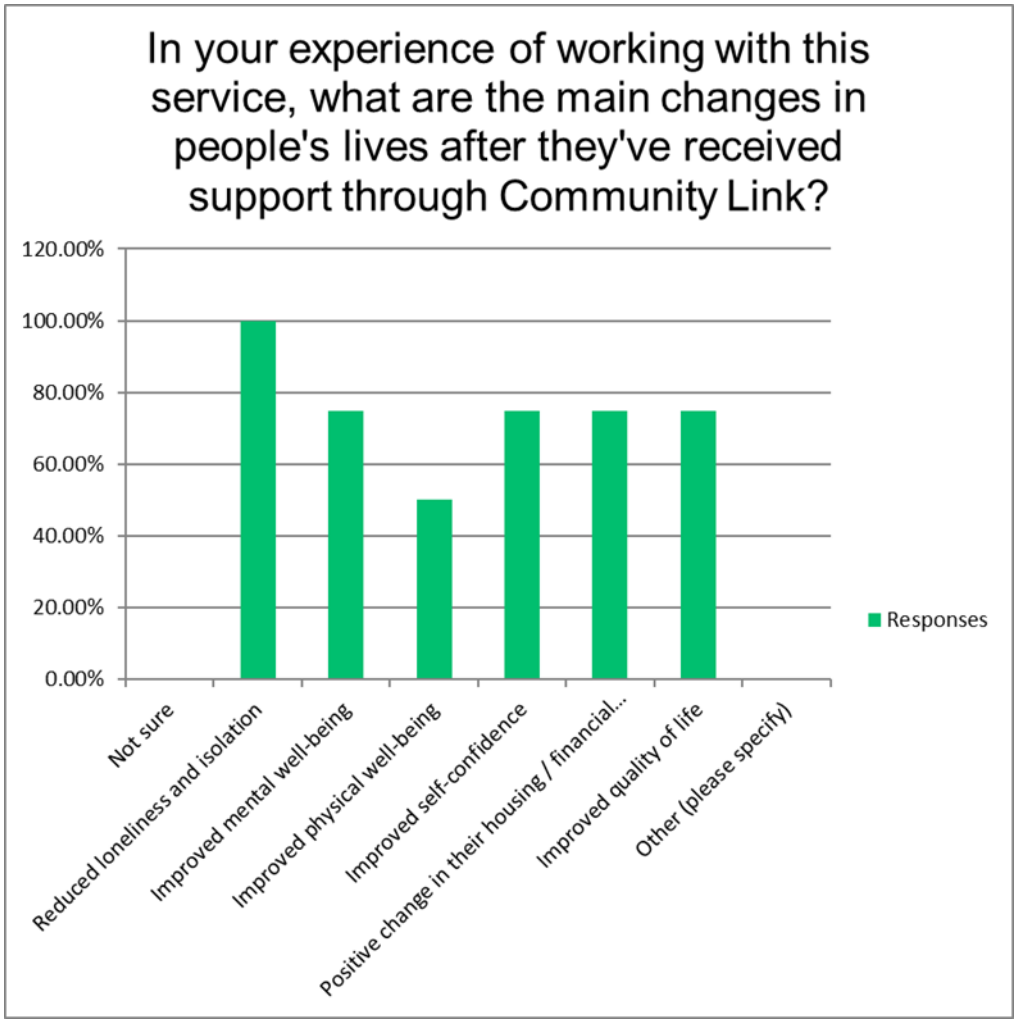
Outcome	**How important is this change out of 10?**
Improved mental health	8.5
Reduced loneliness and isolation	7.5
Improved physical health	6

Feedback from referrals agents

As part of this analysis, time was spent engaging with referral agent to further understand the impact on clients, but also to develop an understanding about the impact on their services. We engaged with one GP, three from the Community Mental Health team, one Occupational therapist and three officers from third sector organisations. 86% were very satisfied with the service, and 100% of those who referred into the service thought it had a positive impact on their services.

"Arfon Community Link has provided local knowledge on services to people who are experiencing mental health problems due to social isolation, loneliness, lack of occupation and challenges with the benefits system. I get feedback from the service with a summary of contact with the service user. Feedback from service users has shown Arfon Community Link has enabled them to improve their quality of life." Community Mental Health Team

The table below also summaries what they what changes they see in the clients or patients, which gives reassurance in the identified well-defined outcomes that need to be managed.



Many of the agents felt that the Community Links service helped to ensure all areas were covered and to ensure there weren't any gaps. One officer felt that for some who were harder to reach, having the partnership with this service offered the best possible outcome for the client.

CASE STUDY A

Awen was a carer for her husband for many years and said that he was her entire world. After his death she felt lost, lonely and low in mood. She had reached a point where she could not see a way forward and explained that she had lost her identity, her role in life and mainly the person she had shared everything with. A family member persuaded her to see the doctor who advised her to contact the Community Link Officer at Mantell Gwynedd.

Initially, she was unsure how this would help her but knew something had to be done, as life was getting bleaker. Awen self-referred by phone. This was a big step for Awen as she and her late husband had always been quite independent.

She explained that when she received an appointment she nearly cancelled and is now glad she didn't. The officer explained that the initial meeting would be an informal chat. Awen expressed that she felt at ease and her thoughts and feelings came flooding out. The officer listened and explained what support and opportunities were available.

Awen received an information pack which included information about activities and organisations which could support her with her specific needs. Awen was encouraged to try one thing at a time and did not feel pressurised to take part until she was ready.

Awen now regularly attends a walking group and this has helped her to integrate back into society. She has met new people and feels that this activity is benefiting her well-being both physically and emotionally. She has joined a yoga class and regularly attends the gym and has also started going to the library and is reading novels again. Her next step is to learn IT skills.

Awen explained that she now has a purpose in life again. She still struggles with losing her husband but by keeping fit and busy, life does not feel as empty. The information, listening ear and the encouragement from The Community Link Officer has given her a life-line to continue to make the most of life and to experience new things.

SROI results

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

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

The results in Table 4 indicate a positive return for individuals who were referred to the Community Link Officer and experienced positive outcomes. This is based on current data but also forecasting results based on secondary research.

Table 4 - Present Value Created per Individual Involved

Stakeholder	Average value for each individual involved
Individuals	£1,394

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	£405,481
Investment value	£57,757
Net present value (present value minus investment)	£345,724
Social Return on Investment	**£6.79:1**

The result of £6.79:1 indicates that for each £1 of value invested in Community Link, Arfon Social Prescribing Model, a total of £6.79 of value is created.

Conclusion and Recommendations

This report has demonstrated that the Community Link Arfon Social Prescription Model pilot will create over £400,000 of value, and for each £1 invested, £6.79 of value was created;

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

The main reasons for the increase in value is that more clients have been supported in the period with less financial inputs. Also, further understanding of the importance of the different outcomes helped to ensure a greater understanding of these changes.

However, some recommendation is still given below:

1) **Data collection** – ensuring we have baseline data and having a mid-review and end review are essential for us to understand if there is any change, but also how much change, and whether there are differences in the needs of different individuals. It is therefore recommended that any continuation of this scheme, or indeed any other social prescribing, needs to **invest the time and finances into ensuring suitable systems and processes are in place to measure social value**, and also to extend this to include other important stakeholders such as wider family members and unpaid carers. When such data is collected over a period of time, the potential to use the resultant information to inform decision making is possible. Ultimately, this means that value is not just being measured, but it is being managed to improve the impacts of the project.

   It was also noted that during the review meetings, that 10% of individuals still felt they needed support, and therefore to understand what changes and to understand, perhaps, why there has not been any change, maintaining this relationship is crucial to develop the service.
2) Although he sustainability of other services is beyond the management of Mantell Gwynedd, one common concern raised by staff and partners were the sustainability of services. The short-term funding meant that the work of the Community Link Officer to have alternatives for clients was becoming increasingly hard. Good partnerships are created which ensure the best outcome for clients, however, when these project ends, time is again spent building up new partnerships.
3) **No change** - focus should be given to looking at why 42% of participants said they had experienced no change when they took part in a review meeting. Due to the nature of the service and the problems that might have been present for some time, it may be that further time or support is needed for these clients in order to ensure any changes happen and are sustainable.

   For some clients, they had health conditions – some had 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.

CASE STUDY B

After been made redundant, John was admitted to Ysbyty Gwynedd after several suicide attempts. He spent several weeks in the hospital and was then referred to the Community Link service by his Occupational Therapist.

Following an initial chat with the Community Link Officer, various activities was arranged for him and a plan was co-produced with him. For John, it was extremely important to have a routine and to have activities in his calendar. As well as this, the Officer helped him to look at what transport options was available including the time.

He now volunteers with two different organisations, attends the Men's Sheds programme and also goes to the drop in at Abbey Road Centre in Bangor.

Every day has been filled with activities and he feels much better having a clear routine to follow. Outcomes for John includes a positive change in his mental health and feeling much less isolated within his community.

Examples of the Arfon Community Link officer's work

Example 1 A young person was separated from his partner and child, was awaiting hospital treatment and living in a car. Interventions included the following:

• Support, referrals and advice on how to contact the appropriate people and organisations to help with his circumstances

• Foodbank • Signposting to organisations who can help him plan ahead

• Support in looking for work Outcome of intervention – He is no longer homeless. He has been receiving the appropriate support to address his individual needs. He is now able to cope better with his situation.

Example 2 Male recently made redundant and was feeling worthless, isolated, lonely and in low mood. Interventions included the following:

• Referred to the Volunteer Centre for advice on volunteering opportunities • Referred and supported to attend local groups to suit his needs and interests

• IT training opportunities

• Information on local walking groups Outcome of intervention - Has signed up for IT training, is attending new groups and has started volunteering. He now feels that he has a purpose to his life.

Example 3 A person caring for her mother was feeling overwhelmed with the responsibility Interventions included the following:

• Referral to Carers Outreach Service • Information on Alzheimer's Society

• Signposted to support groups and activities for carers and people living with Dementia

• Information and guidance on the Herbert Protocol (Safe & Found)

• Prescription books, audio books and e-books

• Daily living aids and Telecare

• Information on respite care Outcome of intervention - The carer is attending groups regularly and is feeling supported and has a clearer understanding of the effects of living with Dementia. Mother and daughter are now able to cope better with the situation by making plans and feel more in control of their lives to ensure that they have a safer and more fulfilled future.